Maternal and Child Health Services Title V Block Grant

Virgin Islands

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

VIRGIN ISLANDS DEPARTMENT OF HEALTH
OFFICE OF THE COMMISSIONER

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August 22, 2021

Christopher Dykton, MA
Acting Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Room 5C-26, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Subject: Virgin Islands Title V FY2020 Annual Report/ 2022 Application Program Plan

Dear Mr. Dykton:

Please find attached, the formal application for the Maternal Child Health Services Block Grant application for Fiscal Year 2021, as authorized by Title V of the Social Security Act (as amended by public Law 97-35, 100-71 and 100-93). It complies with the notification requirements of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and OMB control number 0915-0172.

The Maternal and Child Health services Title V Block Grant Guidance and forms for the FY2022 Application and FY2020 Annual Report were fully utilized. All components of the application, annual report and required data forms are electronically submitted with this letter. Assurances and certifications are on file in the program's office as required in the Block Grant guidance.

We look forward to your favorable approval of this document.

Sincerely,

Justa Encarnacion, RN, MBA/HCM
Commissioner of Health

JE/dp

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Despite the impact of the Covid-19 pandemic, the Virgin Islands Department of Health (VIDOH) Maternal Child Health (MCH) Division continues to provide pediatric services to children and children with special health care needs between the ages of 0 and 21. These services include pediatric-newborn, high risk, Special Needs Pediatric Clinic, Immunization, Audiology, Speech Pathology and Neurology Services. To comply with Covid -19 protocols, the MCH clinics continues to operate by appointment. Steps to ensure the safety of staff and clients were implemented to help stop the spread of the virus. Automatic hand sanitizers and soap dispensers were outfitted throughout the clinics and administrative offices. Adequate PPEs were provided for all staff. A temperature scan is conducted on anyone that enters the clinics and offices. The clinics are cleaned and sanitized several times during the day. A Covid-19 informational brochure developed by the MCH Division, is distributed to pediatric clinics and women's health offices in the territory. As of August 23, 2021, 67 pregnant women, 1202 children under the age of 21 and 905 children 18 and younger tested positive for Covid 19 in the territory.

During this reporting period, several health campaigns and outreach activities were conducted to address the priority needs identified in the 2020 needs assessment, to encourage families in healthy behaviors that provide resistance to serious health threats. The campaigns were strategically designed to provide information that encourage families to lead a healthier lifestyle. The division used creative measures such as drive -thru and virtual settings to engage families. A wide range of communication channels that included television, radio, press, and social media were used to promote the campaigns.

To increase awareness of the importance of mental health wellness in the territory's children, MCH launched a Mental Health Awareness campaign during Mental Health Awareness month. A jingle was developed and used to educate families about the importance of good mental health. The division engaged families in a series of outreach activities. A Through the Stages of a Child – Trunk or Treat Event was held on the islands of St. John, St. Croix, and St. Thomas. This event was a Drive Thru Community Outreach activity that supported the awareness of well-being and development for young children and their families, engaging the birth through 8 population. The activity engaged programs under the MCH Division such as Home Visiting, Early Hearing Detection and Intervention Program and the Project LAUNCH Program. The Project LAUNCH Program provided tangible items for children which included 200 sand pails which encouraged "Building Conversations Around Children's Mental Health" as well as children's books and book marks highlighting our Virtual Reading with a Purpose Event. The EHDI program supplied children's educational toys, such as speakers that stimulates hearing. The MIECHV program offered readings books in both Spanish and English to encourage reading. VI MCH also hosted a Drive-Inn Movie territory-wide. The movies Soul and Inside-Out were strategically chosen. The movies focused on emotions and has moved families to look inside their own minds. Children received free popcorn, a drink, and a snack. The event was well attended and enjoyed by families. Over 500 families attended the free Movie Night territory-wide, and over 300 attended the trunk or treat drive thru activities. https://fb.watch/7AFn38sTQy/

In conjunction with the Northeast and Caribbean MHTTC, the Project Launch Program conducted a Youth Mental Health First Aid Training. Participants learned how to identify, understand, and respond to signs of mental illness and substance abuse disorder in youth. The training also allowed participants to be able to observe common signs and symptoms of mental illnesses and substance use in children and adolescents, how to support children and adolescents in crisis, and how to help connect them with someone who can provide appropriate help. 13 participants representing the islands of St. Thomas and St. Croix indicated really enjoyed the information and found it timely and

beneficial for their field of work. The training was opened to Home Visiting Nurses, MCH Nurses/Select Staff and the Project LAUNCH Program and only allowed for 15 participants.

MCH collaborated with the Department of Education STT/STJ district and conducted an Educators Mental Health Matters" workshop. The workshop provided VIDE Teachers, Paraprofessional, Counselors, & Nurses with practical and engaging information, resources, and tools to support their mental health and well-being. Virtually completed, the program engaged over 185 participants and had incredible conversations and presentations for those who serve children in the age group 0-8. Presentations included representation from the Division of Behavioral Health at DOH on coping skills, insight on "The Brain's responses to stimuli and Trauma", "Understanding the Language of Challenging Behaviors", breathing and mindful movement techniques, "How to Manage Stress", a 'Soca Fitness" work out session, and resources for how to support one's own mental health. Presenters represented clinical psychologist, yoga instructors, fitness instructors, and mental health therapists. The training was held in the St. Croix district in August. MCH wrapped up a wonderful month of activities by engaging the MCH staff in a Mental Health Professional Development Day that focused on self-care for the staff. Employees received massages, engaged in a yoga session, and participated in team building and other activities.

The Project Launch program engaged children between the ages of 0 and 8 and their families in virtual "Reading with a Purpose" activities. The activities integrated attention to both mental health and wellness through specific themes presented in the works of USVI & Caribbean authors. Through the participation of a licensed mental health provider, the subject matter of the chosen author was further integrated with tangible take-aways and activities for participants to utilize during the session and in their daily lives. Families received physical copies of the chosen book to families throughout the territory and supported the development of a reading and resource library at MCH clinics.

Project Launch also conducted virtual cafes to engage families during Covid-19. Parent Cafes are physically and emotionally safe spaces where parents and caregivers talk about the challenges and victories of raising a family. Twenty-seven (27) families participated in each of the cafes conducted. Parent engagement and feedback was highly favorable, and many indicated the desire for future events. Survey results indicated that new strategies were learned when parents encounter challenges when dealing with families and allowed many persons to reflect on their strengths.

The EHDI Program continues to conduct hearing screenings on all newborn babies born in the territory. In addition to daily newborn hearing screenings, the program also screened 72 children in the Early Head start Program, 21 Lockhart Elementary school K-5 students and 52 ESL first and second graders at the Jane E. Tuitt Elementary School and 33 students in Kinder Camp summer camp program.

The impact of the Covid-19 pandemic created a significant shift to how home visits are conducted. Due to the State of Emergency, the Maternal Infants Early Child Homevisting Program (MIECHV) cannot conduct in person home visits at this time. The MIECHV program pivoted to virtual visits to families with some staff members working from home while others remained in the office. Staff were previously equipped with technological devices for satellite work due to the hurricanes experienced in 2017. Home visiting staff members were able to switch to virtual work immediately. Despite all, the MIECHV program was acknowledged for meeting the requirements for demonstration of improvement in benchmark areas after submittal of the Annual Performance Report.

Perinatal Infant Health

VI MCH welcomes Dr. Debra Wright-Francis, OBGYN to the MCH team. Dr. Francis provides service to our prenatal population in the MCH clinic. In the interim, 15 new patients registered for prenatal care. 8 of the 15 new clients began their prenatal care in their first trimester. In September the OB/GYN availability will increase to render full time services.

Since her inception, Dr. Francis has developed several partnerships to ensure continuum of care for prenatal clients. A partnership between the Family Planning and MCH was established to provide Colposcopies and endometrial biopsies to GYN patients. Collaboration with the pediatric team has been established to provide on the spot coverage for postpartum patients during the F/U visits for infants. This partnership will provide facilities for colposcopies for prenatal clients if needed.

Child Health

To address obesity in children and their families, MCH launched a "Let's Get Active Campaign". Every Thursday, VI MCH hosts a live virtual online soca aerobics class. A fitness instructor engages families in a host of physical activities to improve the health and reduce the risk of developing diseases such as type 2 diabetes in children. Over 12,000 families viewed the very first class. Weekly, over 1,000 families participate in the Facebook live virtual soca aerobics class. The MCH Division continues to promote exercise and good diet to help reduce the risk of obesity in children and their families. https://fb.watch/7zLJchzkpJ/

To help families improve food choices and to encourage the integration of exercise into daily activities, VI MCH launched a nutrition education campaign in support of National Nutrition Month. A Nutrition jingle and video promoting healthy eating was created. MCH partnered with the Women & Infant Children (WIC) program and held the "Let's Talk Nutrition Talk Show". The show was hosted by WIC and MCH employees. Each week, three youth panelists engaged in discussion about the importance of healthy eating and exercise. The panelist ranged from 3 to 18 years old. Over a course of 4 weeks 3,054 families engaged in the virtual live activity. 1,100 families viewed the first episode and shared positive feedback. The second week 2,585 families viewed, the third week, 632 families and on week four, 732 families viewed. https://fb.watch/7zM2O1uibx/

A virtual "Let's Cook VI Style Cooking Activity" was held during National Nutrition Month. The focus of the activity was to encourage families and children within the VI community to find nutritious ways towards a healthier lifestyle. Children and parents received insight on this topic from a member of the WIC Program while enhancing their culinary skills with Chef Julius Jackson and his family. The Project LAUNCH team provided an opportunity for children to learn new skills and engage with family members despite the virtual circumstances. The activity encouraged children and their families to connect over meals and provided the opportunity to highlight moments for family strengthening while cooking a healthy, delicious meal.

MCH partnered with the Communicable Diseases Division, the Department of Education and the Department of Human Services Head Start program and hosted a Drive Thru territory-wide back to school drive. Over 1,500 school aged children received a backpack filled with school supplies and a back-to-school t-shirt. The activity also provided children with music, life size characters, a magician, a clown, and free ice cream. The vaccine jingle was played throughout the activities to encourage families to get children ages 12 and up Covid 19 vaccinated.

During autism awareness month in April, VI MCH provided opportunities to increase the understanding and acceptance of individuals with autism by sharing educational information. The information was shared through ads aired on radio stations across the territory. As we continue to promote the well-being of children and their families, it is our goal to see all children and families receive quality, holistic health care.

Adolescent Health

VI MCH hosted a Virtual Live "Let's Talk Youth Mental Health" talk show. The show was live streamed by WTJX a local Public Television Station. Representatives from the MCH & Behavioral Health Divisions engaged the adolescent population in discussion and conversation surrounding the mental health and well-being of our younger population. The show was held in both districts and engaged children ages 10 thru 18. Over 1500 families viewed the event. https://fb.watch/7zN0R48FcZ/

VI MCH created a vaccine jingle and video that provides Covid -19 vaccination education to families. The jingled is played on radio stations across the territory. The video is shared on social media. This mechanism is used to

encourage families to get their children 12 years and older vaccinated. https://www.youtube.com/watch?v=T6t8wM9F71k

Families have been doing their part by staying home as much as possible to help stop the spread of Covid-19. Unfortunately, this have led to many children missing checkups and recommended vaccines. During National Immunization awareness month in August, MCH developed an ad that encouraged families to get children up to date with their childhood vaccinations. The ad was played on radio stations throughout the territory.

Children with Special Health Care Needs

The Division continues to see children born to Zika positive mothers through a neurologist that travels to the territory on a quarterly basis. A pediatric specialty clinic was held to provide free ophthalmology, audiology, neurology, and developmental screenings, aimed to identify any developmental delays in children 5 years and younger. 74 children in the St. Croix district and 96 children in the STT/STJ district were seen for a total of 170 children seen territory wide. The clinic continued the efforts of the 2018 Zika Health Brigade where children born to moms with laboratory evidence of Zika infection were screened to ensure those children were achieving their developmental milestones on time with their peers. In 2018, over 90 children were seen during that clinic. Local community partners who supported this event were JS Therapies, Department of Human Services- Office of Child Care Regulatory Services, Department of Health- Infant and Toddlers Program, Women and Infants Program, and Virgin Islands Partners for Healthy Communities.

Cross Cutting

During National Oral Health Month, in conjunction with the American Dental Association (ADA), MCH launched an Oral Health campaign to educate the territory's children and their families about the importance of good oral health. A brush and floss jingle and video were created. The jingle was played on radio stations across the territory. The video was aired on social media platforms such as Facebook, Instagram, and YouTube.

In partnership with the American Dental Association, the program also conducted a Brush and Floss community outreach on all four islands. Bags filled with a toothbrush, toothpaste, mouth wash, a t-shirt that encourages children to brush and floss twice a day, and school supplies were distributed to over 500 children territory wide. The face of the Brush and Floss Oral Health campaign was displayed on billboards across the territory. The Communicable Diseases Division conducted HIV testing at the outreach. The campaign was a huge success.

MCH is in the process of implementing oral health services in the clinics. The clinical staff will be trained to apply fluoride varnish to clients. Once the training occurs, application of fluoride varnish will be included as part of the annual well child visit.

System Building

Lack of knowledge and adequate resources contribute to families not seeking preventative health services because they may not understand the connection of prevention in relation to their general health. VI MCH must remain in the forefront of providing guidance to communicate the importance and availability of health services for women and children in the territory. The Division is committed to ensuring that women, children, and families receive the necessary education to practice healthy behaviors and seek help when needed.

VI MCH continues to collaborate with other local governmental agencies, other DOH programs as well as community partners. The MIECHV, EHDI, Project Launch and Title V programs are all a part of the MCH Division which makes for a much easier plan for coordination of care. VI MCH is integrated with WIC, Family Planning, Communicable Diseases, Behavioral Health and Birth to Three in respect to Early Intervention. The MCH Program has established a healthy working partnership with the Department of Education and the Department of Human Services MAP and

Head Start programs. These relationships are necessary for continuum of care considering we cater to the same population.

The MCH program serves as an entry to care through partnerships with other public health programs, pediatric providers, and other health care programs. The program seeks to improve the number of clients that follow the recommended standard of care in preventative health clinics through increased education and outreach efforts and collaboration with community partners. Clients need not make multiple appointments or visit multiple clinics to engage in these program services, thereby allowing for comprehensive and cohesive preventative health care.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

In 2020 the Virgin Islands Title V Block Grant continues to support salaries and fringe of MCH employees that provide pediatric, immunization and prenatal services in the territory. Title V funds were used to provide staff with PPEs, such as gowns, mask, face shields and gloves to ensure their safety as we continue to battle the Covid-19 pandemic. Other items such as automatic hand sanitizers and soap dispensers were supported by Title V funds. The flexibility of Title V funds allows VI MCH to determine the best way to serve the unique needs of the territory.

MCH conducted a series of outreach activities during this reporting period. To provide oral health education to families, Title V funds was used to supply toothbrushes, toothpaste, Listerine, “Brush and Floss” T-shirt to children. During Breast cancer awareness month in October, educators in the public and private schools received hand sanitizer and masks. The Division developed a breast cancer awareness brochure, that was also distributed to educators.

Title V funds supported a series of trainings. VI MCH held a mental health training for school nurses and counselors in the territory. The Division partnered with Greater Changes, a behavioral health and wellness organization, and provided insight on behavioral health care services for children and families. The training focused on Bullying and Abuse Recognition and Prevention. Title V also supported an employee professional development day for MCH employees. The training’s primary focus was selfcare. Employees were encouraged to maintain a healthy relationship with self. Staff received massages and engaged in a yoga activity.

Title V funds was used to support several ad campaigns that provided education to MCH families. The Brush and Floss, Nutrition Month and Mental Health ad campaigns aided to increase awareness and provide education to the VI MCH population. Block Grant funds supported the Let’s Get Active campaign and the development of the EHDI and MCH Covid-19 brochures.

III.A.3. MCH Success Story

An MCH 2-year-old client received a cochlear implant. Baby X was not born hearing impaired however was premature with some medical challenges. He underwent several surgical procedures that required prophylactic antibiotics. Because of the extensive use of antibiotics to treat his ailments, he developed hearing loss before the age of one. After several evaluations by the VI MCH audiologist, Baby X was identified as a candidate for a Cochlear Implant and referred to a hospital in Southeast Florida. The implant was scheduled for March 2020 however, due to the onset of the Covid-19 pandemic the surgery was postponed. The surgery was successfully completed in September 2020. Baby X is currently enrolled in speech therapy at the VI MCH clinic. Our newly hired Speech Pathologist is extremely happy with the progress he's making!

Baby Girl Delivered at Maternal Child Health Clinic on St. Croix

On December 7, 2020, Maternal and Child Health staff worked together to safely deliver a baby girl in modular 5 at the Department of Health's Interim Health Center in Estate Richmond. Babies born in this generation can't say they were born at Charles Harwood, also known as the "old hospital," but this special baby will have a unique birth story to tell. Midwife Makeda Kamara shares her account of the joyous day:

"On my way to the clinic on December 7, 2020, I received a text message from Assistant Head Nurse Jacqueline Canton to see if I was coming in. I told her I had a mini problem at home and had been delayed but I was near. A few minutes later, I arrived at the DOH trailers, proceeded to the clinic and forgot my briefcase in my car. I turned to retrieve it and Nurse Canton yelled, 'come in, we'll get it.' 'Hmm,' I thought, 'Something is up.' She gave me a report on the way to trailer #5. One of my ladies arrived at the clinic in active labor. She was wired. I laughed. It's such a joy to see a woman in her primal state totally unaware of her labor. Those are the joyous deliveries. She said she'd been contracting all night but didn't think it was the real deal. She walked from the John F. Kennedy Housing Community to our clinic-- her safe space to be checked. I proceeded to calm her down recognizing she was in transition and in a primal state. She was concerned that she was not prepared. She said, 'Everything is not in place. I'm not ready.' I responded, 'you have all that you need.'"

Assistant Head Nurse Jacqueline Canton is always on the ball. CNA Narcisse is a kind, gentle soul, and caregiver to all. Maternal Child Health staff did what we do - - loving our families as we try to provide women-centered care and promoting humanized birth. Additional staff that assisted with the delivery included Family Care Coordinator Anna Browne who held the mother's toddler until the delivery was completed and Data Entry Clerk Elisa Carmona who brought supplies to the area as needed to avoid nurses moving out of the delivery area.

The baby's mother expressed her gratitude and shared, "The nurses and my midwife were my support team and the entire office assisted in making sure everything turned out. I didn't expect to give birth there nor that day. However, thanks to my midwife, the nurses, and the office staff's swift actions I was able to give birth safely and I'm forever grateful."

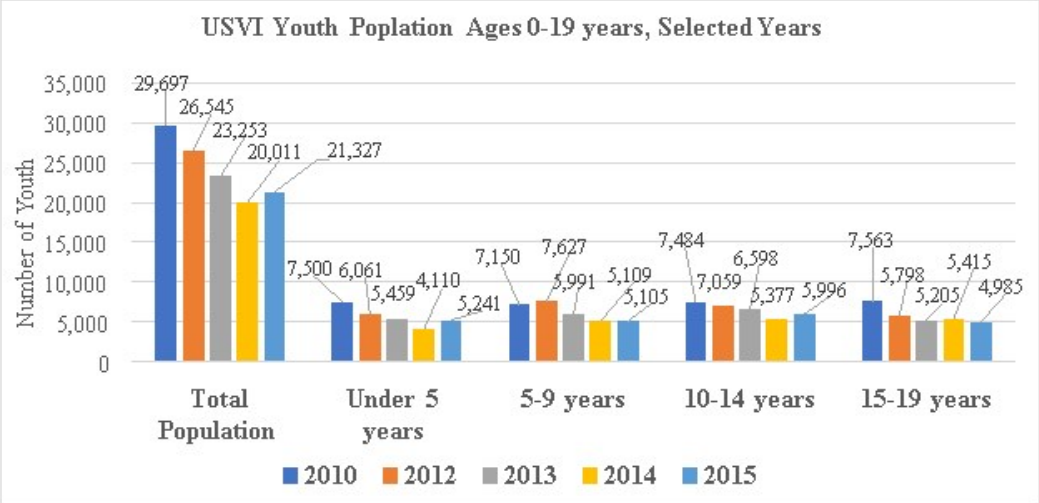
III.B. Overview of the State

Overview of State

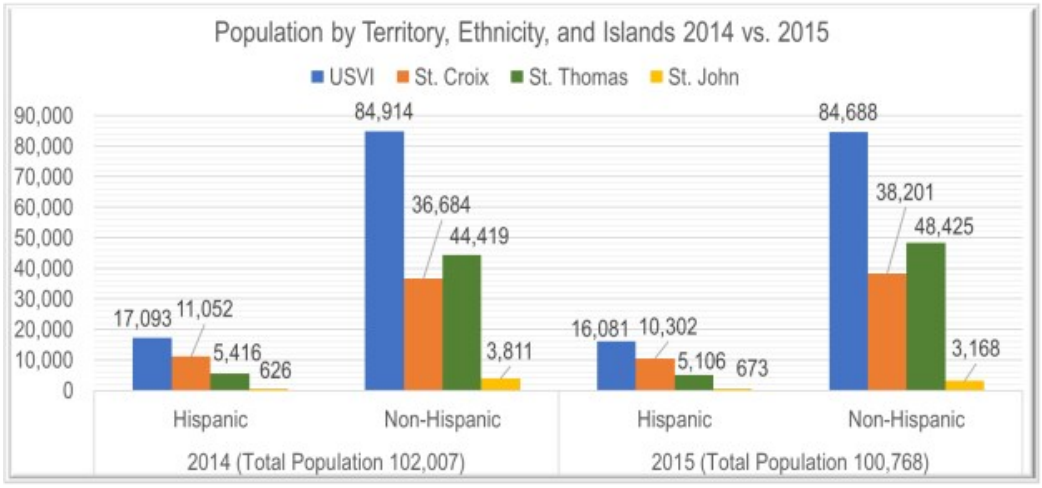
Geography-The United States Virgin Islands (USVI) is an unincorporated territory of the United States, situated at the eastern edge of the Greater Antilles, 43 miles from Puerto Rico and more than 1,100 miles from the US mainland. The territory is geographically part of the Virgin Islands Group, which also contains its near neighbor, the British Virgin Islands (BVI). The USVI population live on 133 square miles with St. Croix being the largest, at 84 sq. miles, St. Thomas, 32 sq. miles, and St. John, 20 sq. miles. The climate of the U.S. Virgin Islands is tropical, hot all year round, with a relatively cooler period from December to April. The temperature range 82-88 degrees. The capital is Charlotte Amalie, St. Thomas and the official language is English.

Population-The 2014 Virgin Islands Community Survey (VICS) reports a population of 102,007, which is a decrease from the 106,405 individuals, reported by the 2010 census. The population of the USVI comprises various groups of people from many places. Currently the largest of Virgin Islanders born outside the territory were born in countries and other independent territories of the Caribbean, especially the eastern Caribbean Islands.

Child Population- According to Kids Count 2019 data book, the child population in the Virgin Islands diminished significantly since the year 2000, decreasing by more than 14,500 children (or 42%). In 2015 children represented 20 % of the population.



Ethnicity- VI population is a multi-ethnic and multiracial population. Of the total population, 77% are black, 10.5% white, 12.5% other races and 17% of the population identify as Hispanic origin according to VICS 2014.



Government-The organization of the GVI is based on the Revised Organic Act of 1954, in which the U.S. Congress declared the USVI to be an unincorporated territory of the United States of America. The U.S. Constitution and this act are the essential documents that govern the USVI.

The GVI has three coequal branches of government: executive, legislative, and judicial. Executive power is vested in the governor, who, along with the lieutenant governor, is elected by qualified USVI voters for a 4-year term. The governor is restricted to two consecutive terms. Legislative power is vested in a unicameral legislature of 15 senators, seven from St. Croix, seven from St. Thomas, and one at large who must reside in St. John. Senatorial elections occur every two years. Judicial power is vested in the District Court of the Virgin Islands, the Supreme Court, and the Superior Court of the Virgin Islands. The USVI is represented in the U.S. House of Representatives by a nonvoting delegate elected by USVI voters for a 2-year term who can sit and vote in committee.

Economy- Economic conditions improved after the impact of hurricanes Irma and Maria in September 2017. According to the United States Virgin Islands Comprehensive Market Analysis (VICMA), during the 12 months ending July 2019, nonfarm payrolls increased by 400 jobs, or 1.2 percent, after declining 11.7 percent during the previous 12 months. The unemployment rate in the territory averaged 6.6 percent during the 12 months ending July 2019, well below the 11.6 percent rate during the 12 months July 2018. For several years, unemployment rates have been higher in the USVI than on the mainland.

In 2017, the Virgin Islands Bureau of Economic Research (VIBER) reported that the major areas of employment are the Government of the Virgin Islands, services, leisure and hospitality and the retail and wholesale trade.

The onset of the Covid-19 pandemic created an increase in the territory's unemployment rate. According to the VI Division of Economic Research, the US Virgin Islands unemployment rate is 172% higher than the fourth quarter of 2019. The territory received $75 million from the federal Coronavirus Aid, Relief and Economic Security, or Cares Act. The money will go toward a number of areas, including the Your Energy Stimulus, or YES program, which will provide a $250 credit for residential customers of the Virgin Islands Water and Power Authority and $500 for commercial customers.

Tourism-Tourism is significant to the economic foundation of the USVI. Despite the lingering effects of hurricanes of 2017, the territory welcomed 1.94 million visitors and received $1.0 billion in tourist related revenue in 2018

(VIBER). The number of jobs in the leisure and hospitality sector, which benefits most directly from tourism declined dramatically following the hurricanes but still accounted for 13 percent of total nonfarm payrolls in the territory during the 12 months ending July 2019.

In an effort to stop the spread of Covid-19 the Governor of the Virgin Islands closed its door to leisure travels. Hotels, Villas, Airbnb accommodations, guest houses, temporary vacation housing, charter vessels and similar businesses were ordered not to accept or book any reservations. This along with CDC's no sail order of cruise ships impacted tourism in the territory, as the corona virus wreak havoc on countries and their economy.

Poverty-Poverty remains one of the greatest threats to our children's wellbeing in the USVI. 18.4% of families in the USVI were living below poverty level according to the 2014 VICS report. In 2015, the child poverty rate in the Virgin Islands decreased to 30% matching the lowest reported poverty rate for children recorded since 2010 (Kids Count Data Highlights 2019).

Medicaid-Medicaid is a government-sponsored program that aids with health coverage to people with low-incomes. Medicare also called Medical Assistance Program (MAP) is designed to make adequate health care available to children and adults who are unable to meet the cost of their medical need. The program is funded by the federal government and administered at the state level. Clients receive assistance paying for things such as doctor visits, custodial care costs, hospital stays, hotel accommodations and airline cost and more.

CHIP is the Children Health Insurance Program that is offered to children under the age of 19 who make too much to qualify for Medicaid but can't afford regular health insurance. In the VI, CHIP falls under the MAP. All services provided by the CHIP are free including doctor visits and check-ups, vaccinations, hospital care, dental and vision care, lab services, X-rays, prescription and emergency services.

The VI implemented Presumptive Eligibility (PE) as another entrance to enroll into Medicaid/CHIP Programs. The PE process allows uninsured individuals who need medical care to be temporarily determined eligible by certain providers when they appear at the facilities. The PE allow persons to complete a brief PE application and self-attest to all information on that application and be immediately determined eligible if they qualify, and receive services immediately paid for by the Medicaid and CHIP program. VI enrollees do not have the freedom of choice (FOC) to go to any provider that they would like to receive service from as Medicaid employees in the states.

Due to the Medical cap imposed by congress, the territory's residents are not eligible for the Supplemental Security

Income (SSI) Program which provides assistive devices, therapeutic or rehabilitative services beyond acute care to children under the age of 16 with disabilities. The Title V program provides these services on a limited case by case basis.

Education-The public education system sustained significant disruption as a result of hurricanes Irma and Maria in 2017. Opening for some schools were delayed because they were used as shelters, schools were deemed condemned and the facility that housed the school lunch program was destroyed. Virgin Islands Department of Education (VIDE) saw a reduction in enrollment in school year (SY) 2017-2018 for a total enrolment of 10,868.

The reduction in enrollment continued during SY 2018-2019. VIDE reported 10,718 students enrolled in 25 public schools in the VI. Further broken down by level, 5,593 students were enrolled in 16 elementary schools, 1,716 students were enrolled in 5 junior high students and 3,409 students were enrolled in 4 high schools.

The onset of the Covid-19 pandemic in March of 2020 caused the VIDE to restructure the 2019-2020 school year. VIDE suspended in person teaching and implemented remote learning. Computers and internet devices were distributed to students who needed these items. Priority was given to 12th grade students earning less than a 70% GPA requirement as of March 17, 2020.

The online educational platforms, Edmentum, Acellus and iReady remained accessible through the end of the school year to allow students the opportunity to improve their grades. VIDE consolidated breakfast and lunch distributions in its "No VI Child Goes Hungry Initiative." In an effort to stop the spread of the virus, all school activities were cancelled including sports activities, prom and graduation. However, a virtual graduation was held for graduating seniors.

Head Start and Early Head Start provides free learning and developmental services to children birth to 5 years of age and pregnant women. There are only two Early Head Start programs in the territory and they are both located in the St. Croix district. In the 2019 edition of Kids Count during the 2015-2016 school years 158 children ages 0-3 were enrolled in early head start programs throughout the territory. There were 45 Head Start centers in the territory, 26 in St. Croix, 18 in St. Thomas and 1 in St. John. During the 2015-2016 school years, 965 total children were served.

Housing-The average price for homes on St. Croix and St. Thomas rose to $368,000 during the first seven months of 2019, a 10 percent increase from the same period in 2018. Demand or sales housing, particularly by non-residents declined dramatically following the hurricanes but has since resumed. Supply remain limited, however with some severely damaged homes for sale yet to return to the market and many other being converted to rental units in response for tight rental market conditions. As a result, the inventory of homes for sale declined in the territory and prices increased during the past year.

Relatively low incomes, high construction cost, limited developable land, and strong demand by non-residents of the territory seeking to buy a home have contributed to an ongoing affordability problem for residents of the territory seeking to purchase a home. Homeownership in the territory is also limited by significant barriers associated with financing. The largest of these barriers is homeowner's insurance, which was about four times more expensive than the states as a whole before the hurricanes and is estimated to have increased as much as 20 percent since the hurricanes of 2017.

Historically, renter households in the territory spend a larger portion of their income on rent that those in the rest of the nation. This issue has been compounded by rapidly increasing rent since the hurricanes. Based on the most recent data available, the median gross monthly rent was 848, which represented 39 percent of the median monthly income

for renter households. The high cost of living and relatively low wages in the territory, subsidized and other low-income rental housing is extremely important. Subsidized housing accounts for 25 percent of the total rental inventory in the VI. The primary provider of subsidized housing in the territory is the Virgin Islands Housing Authority (VIHA) that manages 26 public housing communities with a total 3,014 units.

Environment- More than two years ago, the VI experienced two category five hurricanes that came two weeks of each other. The impact was devastating to homes, building and infrastructure. As hurricane season begins on June 1st, the territory's lead agencies encourage residents to begin preparation.

The environmental hazards associated with severe weather such as hurricanes can give rise to all sorts of covered losses, such as property damage and bodily and personal injury, environmental hazards and property coverage. It is extremely important that the Virgin Islands manage these risks by preparing to immediately and persistently pursue insurance coverage rights.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

There was no update to the key data included in the current needs assessment.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

The development of the 2020 five-year Needs Assessment is being conducted in accordance with Title V legislation (Sec 505(a)(1)) which requires that the Territory-wide five-year Needs Assessment identifies needs in three key areas, as is consistent with articulated health status goals and national health objectives. The three areas of need that the Needs Assessment is to address are:

1. Preventive and primary care services for pregnant women, mothers, and infants up to age one.
2. Preventive and primary care services for children.
3. Services for children with special health care needs.

Given this scope, the CERC team held regular meetings with key USVI Title V MCH & CSHCN (herein after, Title V) personnel to obtain information from key administrative and secondary data sources that were available and could be accessed to cull relevant data to inform the development of the Title V Needs Assessment.

Because of the foundational role of the Needs Assessment in the development of the Title V grant application, it was crucial to the CERC team that the most current and relevant administrative and secondary data available to utilized in delineating the Territory's needs in the key areas of focus.

Vision and Mission – Title V

In its description of the Maternal and Child Health & Children with Special Health Care Needs (MCH & CSHCN), MCH & CSHCN Vision and Mission, the V.I. Department of Health notes the vision of the MCH & CSHCN program: *to see all children and families receiving as their right, quality, holistic health care* and the mission: *to provide the clients and community we serve with accessible, family-centered health services that promote the well-being of children and families in an environment that is inviting, courteous, respectful and values patient confidentiality*.

Goals – Title V

The goals of the USVI's MCH & CSHCN program focus on areas that align with the priority areas for the (to be completed)

1. Facilitate development of a system of care in the territory that improves the health of women of childbearing age, infants, children, and adolescents through availability of appropriate services that optimize health, growth and development.
2. Assure access to quality health care for women and infants, especially those in low income and vulnerable populations, in order to promote and improve pregnancy and birth outcomes.
3. Improve the health status of children and adolescents to age 21, including those with special health care needs, disabilities or chronic illnesses diagnosed at any time during childhood, through comprehensive, coordinated, family-centered, culturally competent, primary and preventive care.
4. Provide a system of care that eliminates barriers and health disparities for vulnerable and unserved or underserved populations.
5. Provide on-going and continuous evaluation of services and systems throughout the territory related to improving the health status of women, infants, children, children with special health care needs, adolescents and families.
6. Enhance program planning and promote policies that will strengthen MCH infrastructure.
7. Optimize perinatal outcomes through prevention of maternal and infant deaths and other adverse outcomes by promoting preconception health, utilization of appropriate services, assuring early entry into prenatal care and improving perinatal care

Leadership

The 2020 Title V needs assessment efforts were led by the USVI's MCH & CSHCN Administrative team, guided by a Territorial Director, who reports to the Deputy Commissioner for Health Promotion and Disease Prevention. Key MCH & CSHCN team members, along with members of the CERC team formed a Needs Assessment Committee which met regularly throughout the needs assessment process. Additionally, the Title V Community Advisory Group was identified to provide feedback on working drafts and to participate in the prioritization of needs.

Methodology

The team relied on administrative and secondary data to complete the Needs Assessment. However, though no primary data were collected during the course of the completion of the Title V Needs Assessment, much of the secondary data utilized represented data collected by the CERC team for previously completed Needs Assessments, updates to earlier environmental scans completed on the Head Start and Early Head Start programs in the Territory, or fulfillment of data and reporting requirements of the V.I. Department of Health (YRBS and BRFSS) survey data. The administrative and secondary data utilized reflected both quantitative and qualitative data – from key information interviews and focus group discussions. Additionally, a recently completed needs assessment of the Territory's Project LAUNCH served as a resource, along with data from the most recent MCH Jurisdictional survey conducted by National Opinion Research Center (NORC) at the University of Chicago.

Descriptive statistics were generated to summarize key findings and are highlighted in the *Findings* section of this summary. Findings most relevant to the three areas of focus with respect to needs for the Territory, within the framework of the goals and priorities of the USVI Title V program are noted.

Stakeholder Involvement in the Needs Assessment

Key stakeholder involvement in the completion of the Needs Assessment will include the engagement of the Territory's Title V Community Advisory Group which is comprised of representatives that reflect the diversity of the clients served by the Title V program and also represent organizations and stakeholder groups that advocate for, support, and provided services to clients served by Title V. The Title V Community Advisory Group reviewed the Summary Needs Assessment and provided feedback that is reflected in this final document. The Title V Community Advisory Group will also be actively engaged and will provide feedback on the more expansive and expended version of the Needs Assessment.

Other stakeholder input will be sought and included as the summary Needs Assessment as well as the more expansive Needs Assessment will be posted to the Department's website and a Comment Period will be provided for community members to offer comments on the documents. All comments received will be reviewed and, as appropriate, the documents will be revised to reflect consideration of feedback received from various stakeholders/stakeholder groups.

Methods for Assessing Priority Needs

Feedback was sought from key stakeholder groups, to include the Title V Community Advisory Group, which is comprised of persons representing key groups in the USVI community. Additionally, representatives of key collaborating and partner agencies have been identified for participating in the determination of priority needs. Prioritization considers current program goals, available resources, program capacity, and clients' needs and challenges.

Methods for Assessing State Capacity

Data Sources

Most of the data sources used in the development of the Needs Assessment were referenced in the discussion of the Methodology utilized for completing the Title V Needs Assessment. However, they are again presented here, but at a more granular level of detail. To complete the Title V Needs Assessment, several data sources were used to ensure that the most relevant data would be used to address key areas within the Needs Assessment. First, two recently completed needs assessments were used, specifically the Needs Assessment of the Territory's Early Childhood Care and Education Mixed Delivery System (August 2020) and the Community Needs Assessment focused on the needs of vulnerable children and families in the Territory in the aftermath of Hurricanes Irma and Maria (2019). Additionally, the most recent administration of the MCH Jurisdictional Survey (NORC, 2019-2010) and the Youth Risk Behavior Survey (YRBS) in the Territory (2018) were used to inform the Needs Assessment. Finally, relevant data from the most recent *KidsCount* Data Book for the USVI (CFVI, 2020), relevant FQHC UDS data from HRSA's website for the past three fiscal years (2017-2019), as well as Title V program data provided by staff were used in the development of the Needs Assessment.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Women/Maternal Health

Getting early and regular prenatal care improves the chances of a healthy pregnancy. This care can begin even before pregnancy with a pre-pregnancy care visit to a health care provider (NICHC/NIH). In the USVI between 2017 and 2019, the FQHCs served 2131 prenatal patients, of which more than 60% consistently access prenatal care in their first trimester. Both FQHCs have witnessed modest increases in the number of prenatal patients served at their facilities in 2018 and 2019, at STEEMCC there was a 13% (368 -- 416) increase while FHC the increase was 11% (323 -- 359). Of the women ages 18-44 who participated in the MCH Jurisdictional survey (NORC 2019), 77% indicated having a preventive medical visit in the past year (n=143).

Perinatal/Infant Health

The MCH & CSHCN program had three key performance indicators (KPIs) for FY2020 related to perinatal/infant health and both indicators were met during the first quarter of the fiscal year (VIDOH FY2021 Budget Hearing Testimony). Specifically, the KPIs related to newborn screenings: 1) Ensure 80% of newborns receive a hearing screen within the first 30 days of birth; achievement: 82% of newborns screened within timeframe set during the first quarter; 2) Ensure 85% of genetic screening performed prior to hospital discharge; achievement in first quarter of FY2020: 94% of newborns had genetic screening prior to leaving the hospitals; 3) Reduce the percent of infants lost to follow-up after not passing a physiologic newborn hearing screening exam prior to discharge from newborn nursery by utilizing targeted and measurable interventions annually. Target 90%; achievement 100%.

The FHQCs data show that on St. Thomas the percentage of newborns with low or very low birth weight is less than 10% annually, while in St. Croix the percentage of newborns with low or very low birth weight is consistently higher with16% of newborns classified as such in 2018.

Based on the 2019 MCH Jurisdictional survey, respondents indicated that 15% of children included in the sample (n=207) were low birth weight infants and the same percentage were born pre-term. Further, of the children born pre-term, the largest percentage (28%) were to mothers 35 years of age and older.

Child Health – 2019 MCH Jurisdictional Survey Results

With respect to children's health status, respondents identified 83% of children as being in "excellent or very good" health and 15% as being in "good" health (n=207). For children not identified as having special health care needs, responses revealed approximately 11% of children classified as having decayed teeth or cavities in the past year. Of 82 adolescents in the sample, while 45% were classified as "normal weight", 20% were classified as "overweight" and 28% were classified as "obese". With respect to health insurance, respondents reported that, at the time of the survey, 88% of children were insured (n=207). With respect to access to heath needed health care, respondents indicated that, in the past year, 10% of children did not receive needed heath care.

Children with Special Health Care Needs – 2019 MCH Jurisdictional Survey Results

Of the survey respondents, 13% indicated having children with special healthcare needs [n=207 children in sample]. In response to a query regarding receipt of care in a "well-functioning system", responses reflected that only 11% of CSHCN were receiving care in a "well-functioning system" (n=38). Further, respondents identified 63% of children as ***not*** having a medical home. With respect to access to needed health care, respondents indicated that, in the past year, 20% of CSHCNs did not receive health care needed (n=38). For adolescents (ages 12-17) with special health care needs, respondents reported that 62% have received the necessary services to make the necessary transitions to adult health care (n=12).

Adolescent Health – 2018 YRBS

The 2017 State Youth Risk Behavior Survey and the 2017 Middle School Youth Risk Behavior Survey (CDC), modified by adding questions of interest to the local Department of Health-Division of Mental (Behavioral) Health, Substance Abuse and Drug Dependency Services-State Prevention Framework Partnership for Success Grant.

The results reveal that USVI youth may be engaging in health-related behaviors that may have implications for health outcomes that increase risk of unintentional injuries and violence; sexual and reproductive health, to include exposure to infectious disease and unintended pregnancies; social problems; tobacco and drug use; unhealthy dietary behaviors and physical inactivity and a range of health conditions such as overweight and obesity, diabetes, and cardiovascular disease.

30% reported using marijuana at least once and when asked about the number of times they used marijuana during the 30 days prior to the survey, while 83.9% reported no use, 16.1% reported using marijuana at least 1 time, with 4.3% reporting using marijuana 20 or more times. While only 6.6% ever tried smoking a cigarette, the majority tried smoking before the age of 17. With regards to the use of e-cigarettes 21% self-reported ever using an electronic vapor product but only 3.9% reported current (past 30-day) use.

Among youth responding to the question regarding their first sexual experience, 7.2% reported having sexual intercourse for the first time at 15 years old, followed by 6.7% at 16 years old. Notably, 7.9% reported sexual intercourse at 13 years or younger. The most frequently reported pregnancy prevention method was condoms, reported by approximately 18% of participants, while 5.1% reported using no method and 57.1% of the sexually active youth reported using a condom at last sexual intercourse.

Cross-cutting/Life Course

Oral Health

Both FQHCs have expanded their offerings of dental services in the past few years. In CY 2017 over one-third of clients received dental services at FHC and at STEEMCC, just over one-fourth of clients received dental services. FHC is set to add another 12 chairs soon (KI, FHC CEO, November 2018) because the current capacity cannot meet the existing demand for dental services. STEEMCC added a separate dental facility due to the high demand for these services from clients and the recognition that the needed dental services were not being provided. In 2019, FHC served 3909 dental patients, a 13% increase over 2017. Similarly, at STEEMCC 2631 dental patients were served. This represents a 61% increase in the number of dental patients served in 2017. (HRSA UDS Data, 2017-2019)

Dental health is also important for the HS and EHS populations and an indicator of access to health care that is captured for children from vulnerable families participating in both programs and the FQHCs provide valuable preventive dental care screening services to this population. In the school tear following hurricanes Irma and Maria, SY2017-2018, only 2 of 65 HS children identified as needing additional dental treatment received the needed treatment – compared to 100% of HS children identified as needing preventive dental care receiving such care during SY2016-2017. (CFVI CAN, 2019).

Based on the MCH Jurisdictional survey (2020), of 198 children ages 1 through 17 for which data were available, 12% reported “frequent or chronic tooth decay or cavities”.

Health Insurance

In the USVI, access to healthcare needs and services are addressed through Medicaid, Medicare, personal finances (uninsured) or third-party healthcare insurance. The 2015 VICS reported that 22% of the population did not have health insurance coverage. In 2016, approximately 55% of children younger than 9 years old were receiving medical services through Medicaid and 61% of children in the Territory between the ages of 10 and 19 years old were uninsured (Health Resources and Services Administration UDS Data Center, 2016).

Access to health care is one of the core elements of both the HS and EHS programs. The literature shows that HS participation increases the chances of children from low income families obtaining dental care, health insurance coverage and positive health outcomes (Lee, 2016). For school years 2015-2016 and 2016-2017, 99% of children had insurance at the end of the school years. However, for SY 2017-2018, the school year in which the USVI experienced significant disruptions due to the passage of Hurricanes Irma and Maria, only about 2 in 5 HS children had insurance coverage at the beginning of the school year and approximately 87% (775 of 894) had health insurance at the end of the school year. (CFVI CNA pgs. 105-106).

Based on the results of the BRFSS 2016, 75% of Virgin Islanders reported having a personal doctor or health care provider and eight out of every ten indicated having health care coverage (n=1266).

Behavioral Health -- Children and Youth

A total of 34 schools with students enrolled in intermediate elementary grades (4th through 6th) participated in the study, a total of 1,344 students attended private and parochial schools and 2,606 attended public schools completed a 10-item survey, the Child Trauma Screening Questionnaire (CTSQ). As previously shared, this instrument is designed to assess traumatic stress reactions in children following a potentially traumatic event and serves as a risk assessment tool to predict the likely onset of PTSD. Based on the findings from the survey, there is evidence that elementary aged students across the Territory may have future issues with PTSD as a result of experiencing Hurricane Irma and/or Hurricane Maria and that girls may have more challenges with future PTSD than boys.

Additionally, 633 students ranging in age from 11-19 years completed the Child PTSD Screening Scale (CPSS), a 24-item survey designed for use with children to screen for the presence of post-traumatic stress symptoms. According to findings of this study, approximately 42.5% of the secondary students with enough data to compute a total score (*n=501*) may be at risk for PTSD.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

The Virgin Islands Department of Health (VIDOH) is the official Title V agency for the U.S. Virgin Islands. Based on this designation, the VIDOH is the designated agency in the USVI for administering the MCH & CSHCN Program in the Territory (V.I.C., Title 19, Chapter 7, Section 151). By administering the Title V MCH & CSHCN Program as one integrated program, the VIDOH can better and more efficiently coordinate services to full range of clients. The program provides health care services for mothers, infants, children, youth and adolescents and their families. The program also provides and coordinates a system of preventive and primary health care services for the targeted population.

Led by a Director who is supported by a team of credentialed, experienced clinical, administrative, and supervisory personnel, the MCH & CSHCN Program focuses on improving and maintaining the health status of women, infants, children, and adolescents (including children and adolescents with special healthcare needs) through a range of services. These services include prenatal and high-risk prenatal care clinics, postpartum care, well childcare, high risk infant and pediatric clinics, care coordination and access to pediatric sub-specialty care for children and adolescents with special health care needs. Services are provided in accordance with SSA -Title V law related to children with special health care needs.

III.C.2.b.ii.b. Agency Capacity

Title 3, Title 19, and Title 27 of the Virgin Islands Code designate the VI Department of Health (VIDOH) as the local government agency responsible for providing public health services to USVI residents. This responsibility involves protecting and improving the community's health through health promotion and preventative initiatives. Preventative measures are aimed at improving overall health and reducing health care costs, particularly related to chronic disease.

The VIDOH functions as the Territory's regulatory agency as well as the Territory's public health agency. In its dual capacity, VIDOH has oversight of twenty-six programs; serves as the lead agency for Emergency Services Function 8 or (ESF-8); and oversees hospitals during a declared emergency or disaster. Currently, VIDOH also serves as the lead agency relative to the COVID-19.

The VIDOH operates health clinics on St. Croix, St. Thomas and St. John and see clients based on appointments, though walk-ins are accepted. The agency's capacity to deliver services to children and families remains limited and below pre-hurricane levels, though some progress has been made in both the capacity and timeliness of service provision.

On St. Croix, the VIDOH administrative offices and clinics are located at the Charles Harwood Memorial Complex (CHMC) in Estate Richmond, near the town of Christiansted. Because of damage sustained from Hurricanes Irma and Maria, the VIDOH is currently operating administrative functions as well as clinics from modular facilities. Emergency Medical Services (EMS) previously based at the Juan F. Luis Hospital and Medical Center (JFL) are now based at CHMC.

On St. Thomas, VIDOH provides services out of three main sites: (1) the Schneider Regional Medical Center [community health, behavioral health, and emergency medical services]; (2) the ElaineCo building [MCH & CSHCN program]; and (3) Knud Hansen Memorial Complex [other programs such as the HIV/AIDS program, environmental health, and vital records].

On St. John, in the aftermath of Hurricane Irma, the VIDOH is functioning out of the Morris F. deCastro Clinic in Cruz Bay, which sustained minimal damage, unlike the Myrah Keating Smith Community Health Center (MKS), which was rendered unfit for use due to severe wind and water damage. VIDOH services on St. John have not yet returned to pre-hurricane levels, though significant progress has been made to restore service capacity over the past year.

III.C.2.b.ii.c. MCH Workforce Capacity

In the USVI, the VIDOH is the designated for administering the MCH & CSHCN program pursuant to Title 19, Chapter 7, §151 of the Virgin Islands Code (VIC). The MCH & CSHCN Program offers preventive and primary health care services for mothers, infants, children, and adolescents. These services include prenatal and high-risk prenatal care clinics, postpartum care, well child clinic, immunization, high risk infant and pediatric clinics, care coordination and access to pediatric sub-specialty care for children and adolescents with special health care needs. Other services provided by skilled public health nurses include assessments, anticipatory guidance, parental counseling, education regarding growth and developmental milestones, proper nutrition practices, service/care coordination, and home visiting services to high risk children and their families.

USVI residents are not eligible for the Supplemental Security Income (SSI) Program which provides assistive devices, therapeutic or rehabilitative services beyond acute care to children under the age of 16 with disabilities. The Medical Assistance Program (MAP) does not provide these services, due to the Medicaid Cap imposed by Congress. Yet, on a limited, case by case basis, these services are provided by the Title V Program.

Public health nurses assess the developmental needs of infants and toddlers who are considered at-risk due to psychosocial or biological risk factors. The entry point is a referral to the early intervention services program Infants and Toddlers' (Part C of IDEA) service coordinator to identify newborns as part of the Infants and Toddlers (Part C) Child-Find system. Nursery referrals are received on all high-risk newborns to the MCH & CSHCN clinics in both districts, while infants without any high-risk factors are referred to well child clinics. As a standard practice, high-risk referral patients are screened to receive a home visit and family assessment.

Prenatal services provided through MCH include prenatal intake for new patients in which the history, physical, risk assessment, PAP smear, and laboratory referrals are completed, routine follow-up and counseling, teen prenatal, and perinatal/high risk clinic for the management of obstetrically or medically complex cases. Patients with emergencies are referred to the Obstetrical Unit at the hospital for evaluation and treatment. Diagnostic services, such as ultrasounds and laboratory services, are provided for MCH clients by the hospitals or private facilities. Patients are referred to the WIC Special Nutrition Program for dietary assessments, counseling, and follow-up.

The MCH & CSHCN Program engages in outreach activities to identifies children who have health problems that require intervention, are diagnosed with disabling, or chronic medical conditions, or are at risk. Sources of child find include referrals from the Queen Louise Home for Children, Early Childhood Education, Head Start, Early Head Start, and private providers. Pediatricians, nurses, social workers, a Physical Therapist Assistant, an audiologist, and speech pathologist are the major providers of direct services. The Infants and Toddlers Program employs service coordinators on each island.

Hospital newborns with biological, established, or environmental risks are referred to the Infant or Pediatric High-Risk clinics based on established criteria. At one year of age, infants are reassessed and transition to the Well Child Clinic or the

Pediatric High-Risk Clinic. The Infant and Pediatric High-Risk Clinics offer comprehensive, coordinated, family-centered services. Screening is done for developmental delays using the Ages and Stages (ASQ) Screening Tool. Social workers complete an assessment of the family and home environment, existing support structures, and financial status and clinical staff develop appropriate diagnostic assessment and therapeutic plans. Children with special health care needs are referred to the sub-specialty clinics by the primary care physician and are seen based on appointment.

Additional services and activities under the MCH umbrella include: the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program; Early Hearing Detection and Intervention (EHDI); HRSA-funded Zika MCH Services; and Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), a system that addresses the needs of children ages 0–8 and allows them to thrive in safe, supportive environments and enter school with the social, emotional, cognitive, and physical skills they need to succeed. The MCH & CSHCN Program works collaboratively with several key programs within and outside the VIDOH.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

For the completion of the Territory's ECD MDS Needs Assessment, the Maternal and Child Health and Children with Special Health Care Needs (MCH & CSHCN) Program described the program's partnerships, collaborations, and coordination efforts integral to effectively leading efforts across the Territory to support a comprehensive, coordinated system of preventive and primary care and services for children birth through 21, as well as for pregnant women. Partnerships and collaborations exist with several public/governmental, private, and non-profit organizations.

Current collaborations and partnerships – both formal and informal, exist to support the delivery of services to children B – 5. Formal collaborations exist with entities outside VIDOH and take the form of Memoranda of Agreement (MOAs) or Interagency Agreements (IAs). MOAs with the two FQHCs and IAs with the two local hospitals and the Medical Assistance Program (MAP) (housed in VIDHS), have been established primarily for data sharing, recruitment, and referrals. The MCH & CSHCN program also coordinates with the hospitals to conduct and record results of health and hearing screening for newborns, track the result of genetic testing, and provide needed follow up support to parents.

Currently, though the MCH & CSHCN program collaborates with EHS through an informal collaboration around data, services (hearing screenings), and recruitment, both entities are working on formalizing the collaborative relationship through an MOA. Other informal collaborations are primarily intra-agency support data sharing, services, and/or referrals. Units within VIDOH that collaborate with the MCH & CSHCN program include the WIC program; immunization; nursing services, the Infant and Toddlers Program (Part C), and vital statistics.

There are plans to develop and execute an MOA with VIDE for hearing and vision screening to be provided in the public-school setting for Kindergarten population (5-year old children).

Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)

The MIECHV Program is authorized by Social Security Act, Title V, Section 511 (42 U.S.C. Section 711). The funding supports voluntary, evidence-based home visiting services for at-risk pregnant women and parents of children birth through five years (or through when the child/children enter Kindergarten). Home visits are made by the DOH MCH staff, and all services are performed in the child's natural environment to the extent possible.

States Supplemental Data Initiative (SSDI)

The stated purpose of SSDI is to develop, enhance and expand State Title V MCH data capacity to allow for informed decision making and resource allocation that supports effective, efficient, and quality programming for women, infants, children and youth. Three goals have been set forth to: Build and expand State MCH data capacity to support Title V program efforts and contribute to data driven decision making in MCH programs; Support the State's Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality through improved availability and reporting of timely data; and Advance the utilization of both the minimum and core data sets (M/CDS) for State Title V MCH programs. To date, elements of these goals are still being developed and have not been fully implemented.

Early Hearing Detection and Intervention (EHDI)

The purpose of the EHDI project is to reduce the percent of infants lost to follow-up after missed initial screening or referral for repeat screening, and the development of a tracking system to ensure infants are rescreened and referred for timely diagnostic evaluation, treatment, and early intervention services. Appointments are made for re-screen prior to the infant's discharge. Educational material, which includes information to increase awareness on the EHDI program, is provided to the mother on discharge. Any newborn missed prior to hospital discharge is identified, and the family is contacted through various modalities- phone calls, text, and email. Weekend hearing screenings are completed if needed.

Several Title V staff received training in the Use of the OZ newborn hearing screening database to fill the gaps in the newborn hearing screening program. Prior to this training, a significant number of newborns were being missed in the hospital or were inadequately followed up in the outpatient setting.

Early Childhood Comprehensive Systems (ECCS)

The purpose of the US Virgin Islands Early Childhood Comprehensive Systems (ECCS) Grant is to mitigate toxic stress in infancy and early childhood through the development of a trauma-informed child and family service system and by promoting a protective factors approach to strengthen and support families in their roles as nurturers of their infants and young children. The first Project LAUNCH program to support the social emotional development of children 0-8 was funded after the 2017 hurricanes, and after research evidence that children who experienced the hurricanes are at risk for PTSD. Project LAUNCH grants are designed to build the capacities of adult caregivers of young children to promote healthy social and emotional development; to prevent mental, emotional and behavioral disorders; and to identify and address behavioral concerns before they develop into serious emotional disturbances (SED).

Infant and Toddlers Program (Part C)

The program is fully funded by Part C of the Individuals with Disabilities Education Act (IDEA) with the Department of Health as the Lead Agency. It supplements the Maternal Child Health and Children with Special Health Care Needs (MCH & CSHCN) Program, when public or private resources are otherwise unavailable.

The Infants and Toddlers Program Part C services developmental needs of infant or toddler with special needs. Part C requires that each child's Individualized Family Service Plan (IFSP) must be developed within 45 days of the Infants and Toddlers Program receipt of the referral. Public health nurses assess the developmental needs of infants and toddlers who are at-risk due to psychosocial or biological risk factors. Referrals are made to the early intervention services program Infants and Toddlers' (Part C of IDEA) service coordinator to identify newborns as part of the Infants and Toddlers (Part C) Child-Find system. The lack of qualified professionals on-island and the inability to offer competitive pay for specialized services is a major challenge in providing service to this population.

Women, Infants, and Children Program (WIC)

WIC, administered by the DOH, is the Special Supplemental Nutrition Program for Women, Infants and Children that are designed to improve the health of families who participate by supporting the purchase of specific foods that are designed to supplement their diets with specific nutrients. The program is designed for pregnant, postpartum and breastfeeding women, infants, and children up to age five. To be eligible for WIC the applicant must meet income guidelines, residency requirement, and individual determination as being at "nutritional risk" by a health professional. The DOH reports that an 86% partial breast-feeding rate among WIC post-partum participants was maintained.

To be eligible based on income, applicants' gross income before taxes must fall at or below the U.S. Poverty Income Guidelines for the Territory. A family that participates in the Supplemental Nutrition Assistance Program, Medicaid, or Temporary Assistance for Needy Families is eligible for the WIC program.

Family Planning Program

The Family Planning Clinics offer comprehensive, compassionate, and confidential sexual and reproductive health services for women, men, and adolescents. These include a spectrum of sexual and reproductive health services, including birth control methods, testing and treatment for sexually transmitted infections, well-woman exams, preconception care, pregnancy testing, breast and cervical cancer screening, and postpartum care. Tailored community-based clinical outreach and education programs are also offered.

Medicaid Program

Medicaid (MAP) is a government-sponsored program that helps with health care coverage to people with low-incomes that meet Virgin Islands residency and citizenship criteria. Patients receive assistance paying for things like doctor visits, long-term medical, custodial care costs, hospital stays, and more. All the services provided by the Children's Health Insurance Program (CHIP) for children under 19, are free including doctor visits and check-ups, vaccinations, hospital care, dental and vision care, lab services, X-rays, prescriptions, and emergency services. VI Enrollees do not have the freedom of choice (FOC) to go to any provider that they want to receive services as do Medicaid enrollees in the States.

Income standard for the categorically eligible for a family of one is $15,654. For Aged, Blind or Disabled, for a family of one the standard income level is $20,833. The poverty threshold requirement causes difficulty for uninsured families to qualify for Medical Assistance and creates barriers to health care resources and services. These uninsured individuals are generally unable to afford health insurance premiums.

One limitation of the expanded Medicaid program is that income eligibility will remain fixed at $5,500 for new enrollees—mostly adults without children. This provision will limit the availability of health insurance coverage among lower-income residents. Medicaid coverage is also limited by the federal match formula that requires the Virgin Islands to cover much of the costs of providing coverage.

Role of Parents

The MCH & CSHCN Program is guided by an advisory council, which is charged with the responsibility of advising the Administrative Unit of the MCH & CSHCN Program. Members of the Council include parents and guardians of children with special health care needs and play a vital role in the program planning and evaluation, quantitatively and qualitatively. Parents are involved in preliminary planning and implementation of each program. As members of the Advisory Council, parents assist in developing goals and objectives, long range program planning, identifying service gaps, locating resources, and monitoring the quality of provided services. In line with The DHS commitment towards parent involvement and engagement, the program was successful in hiring the first paid family representative in 2018. Parents are encouraged and invited to attend trainings, workshops, and to join the different special needs councils.

V.I. Interagency Coordinating Council on Homelessness (VIICH)

The Virgin Islands Interagency Council on Homelessness (VIICH) was established within the Department of Human Services by an Executive Order. The VIICH serves as a public/private sector collaboration to prevent and end homelessness in the Virgin Islands through policy and resource development. The Virgin Islands Continuum of Care on Homelessness (CoC) works collaboratively with VIICH to implement the Territorial Crisis Response System. The goals of the VI Interagency Council on Homelessness are to ensure homelessness is a rare experience, a brief experience, and to work toward an end to homelessness in the territory.

The VIICH comprises 26 members appointed by the Governor, with the Commissioner of Human Services and Housing Finance Authority (VIHFA) Executive Director serving as Co-Chairpersons and is responsible for advising the Governor and the Legislature on issues related to the problems of persons who are homeless or at risk of becoming homeless and provide recommendations for joint cooperative efforts and policy initiatives in carrying out programs to meet the needs of the homeless.

State Advisory Council (SAC) Early Childhood Advisory Committee

A multidisciplinary group of governmental, non-governmental and non-profit organizations persons are members of the SAC. Members collectively engage in deliberative dialog to discern best practice approaches to improve the delivery of quality services to children and their families.

V.I. University Center for Excellence in Developmental Disabilities (VIUCEDD)

The Virgin Islands University Center for Excellence in Developmental Disabilities (VIUCEDD) was established in October 1994 and is funded by the U.S. Department of Health and Human Services, Administration on Community Living (ACL), Administration on Intellectual and Developmental Disabilities (AIDD) and National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR). Its mission is to enhance the quality of life for individuals with disabilities and their families and to provide them with tools necessary for independence, productivity, and full inclusion into community life. VIUCEDD continues to be a proactive community partner offering workshops, trainings and community town halls to engage and dialogue with the special needs population and fulfill its goal to coordinate, implement and supervise support services for the families with children with disabilities that promote their independence, self-advocacy and integration in the community.

Vocational Rehabilitation Program (VRP)

The Vocational Rehabilitation Program, administered by the Department of Human Services, is authorized by the Rehabilitation Act of 1973, Public Law 93-112, and its amendments. The VRP assists individuals with disabilities, physical or mental impairments that constitute or result in substantial impediment(s) to employment, by providing those services which will help them to achieve an employment outcome.

Services are offered to eligible individuals with disabilities in preparation for competitive employment including:

supportive employment through Work-Able, a non-profit placement agency; independent living services; provision of a vending stand program for visually impaired individuals; and in-service training programs for staff development.

The Special Services Unit of this program provides services to Disabled Adults and Adult Foster Care, administers the Disabled Persons Fund and provides support for the Community Rehabilitation Facility, Developmental Disabilities Council and cancer care programs, and assists disabled persons in obtaining handicapped parking permits.

Developmental Disabilities Council (DDC)

The DDC's purpose is to improve service systems for individuals with developmental disabilities and to assure that individuals with developmental disabilities and their families participate in the design of, and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life.

Comprised of individuals with disabilities, representatives of the business community, and agency professionals serving the disabled and other interested persons, the DDC reviews and approves proposals for special projects serving persons with developmental disabilities. Council members also assist in the planning of service provider training workshops and related activities.

Office of Child Care & Regulatory Services

This office combines the Child Care Fund Program (CCFP), which provides subsidies for childcare, and the Office of Regulatory Services, that license and ensures quality control of childcare facilities and group homes. In collaboration with several partner agencies, it works to improve the quality of childcare in the territory and to ensure that quality childcare is accessible to all families in the Virgin Islands.

The Child Care Fund is a federal program which provides childcare subsidies to lower income working parents for infant, preschool, and for before- and after-school care, for children up to age 12. It also provides support for quality improvement in the private childcare sector. The program supports both licensed facilities and informal providers who have been selected by parents and approved by DHS.

Regulations as they pertain to the licensing of child care facilities and group homes are accomplished by enforcing the minimum standards for the safety and protection of children in child care facilities, in-home care, group homes, summer camps, and after school programs; insuring compliance with these standards, and regulating such conditions in such facilities through a program of licensing. The CCFP offers protection from unsupervised access to inappropriate television programming and inappropriate internet sites by keeping children of working parents in safe, stimulating, and healthy environments.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Identifying Priority Needs and Linking to Performance Measures

Eight areas have been identified in the application as priority needs for the Virgin Islands.
They are:

1. Increased the number of women that have well women visits (NOM 1):

5,203 women between the ages of 13-50 received well-women visits by the FQHCs, Family Planning, and the MCH Prenatal clinics. The total female population in 2015 ages under 5 to 85 was 54,908 (*2015 United States Virgin Islands Community Survey*). By statistics and excluding the private providers we could be serving approximately 10% of the female population in the territory. By 2024 we would like to see an increase of 10% of women receiving well women's visits at our three sites. This could be attained by adding another Obstetrics and Gynecology position to the staff and the possibility extending services beyond the 8 am to 5 pm hours for working women.

2. Increase the number of families educated on safe sleep practices (NOM 9.5):

No cases of Sleep-related Sudden Unexpected Infant Death (SUID) were reported in the hospital's statistical data of 2019 (*Nurse Liaison Reports 2019*). This trend should continue into the next reporting years as education into the prevention of death is critical to maintaining the low numbers in the Virgin Islands. Mothers in the Maternal, Infant, Early Home Visiting

program continue to report that their babies sometimes sleep with soft bedding. The hospital educates 100 % of the mothers prior to discharge on safe sleep practices for babies providing handouts. The same is continued in the MCH clinics by the providers of newborn health care services.

3. Decrease the number of children with BMI>85% (NOM 14, NOM 18, NOM 20 & NOM 21):

Poor self-esteem has been linked to mental and behavioral conditions. Bullying of overweight children has been linked to increased mental health challenges. Children in the Virgin Islands receive physical education that includes physical activity from ages 5 to 21 while enrolled in a public-school program. Most parochial and private schools offer a similar health education curriculum. However, most children make their own decisions on choices of food to eat outside of partaking in a school lunch program. Childhood obesity more likely carries over to adulthood taking the same self-esteem and health issues into adulthood.
The MCH-CSHN Program would like to increase awareness of the issue in the child-wellness clinics, link parents and children to the Project LAUNCH program for children 0-8 for support services in behavioral health, and continue to support the community to reduce obesity by sponsoring physical activity events, good cooking and eating habits that have taken place this year with the Project LAUNCH program. Increases in healthy eating and exercise should lead to increase in good dental health also.

4. Increase the percent of developmental screenings done in the territory (NOM 17.2 NOM 17.4, NOM 21):

Attention Deficit Disorder/Attention Deficit Hyperactivity is a silent illness that does not show up until well into the development of infants to the toddler stage. Without a medical home, the disorder may go untreated in children until school age. Developmental screening should be as critical to care like immunizations. Lack of insurance prevents parents from asking for additional services and lack of knowledge in the developmental stages by parents may lead to interventions taking place when the child begins school. Utilizing the CDC's *Learn the Signs Act Early* campaign families are provided with the booklets to self-educate on development stages 0 to three. The Zero to Three program serves the population in the territory needing intervention services as soon as a referral is made. ASQ screening are completed several times a year for every child in the Maternal, Infant, Early Childhood home visiting programs. ASQ screening are also conducted by the clinicians in the clinics as needed. Cross training for non-clinical staff on the use of the ASQ tool is a part of the intervention plan for the MCH-CHSH Program to build developmental screening capacity.

5. Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents (NOM 13, NOM 14, NOM 18, & NOM 21):

During the 2017-2019 school year several public schools were consolidated onto one school campus. This allowed for each school to have a school nurse on hand to serve the school population. MCH works with the school nurses to provide preventative health care services on site to school based program. Currently the EDHI program provides hearing screenings at the school sites for the Kindergarten and Sixth grade populations. This outreach has continued since 2015. MCH received two mobile health vans in 2020 via the CMS-Zika grant. These vans will be utilized by the program to provide off-site primary and preventative health care in the schools and neighborhoods of the territory.

It is expected that a pediatrician, nurses, and other support staff will be trained to utilize the van to full capacity so that outreach can be provide on an annual schedule to high risk communities and school sites.

6. Increase percentage of families that participate in transition planning (NOM 17.1, NOM 21, & NOM 25):

Pre-teens and pre-adolescence subgroup in the 0-17 populations are the target groups to identify in transition planning. This group once they passed the child-wellness visits stage tend to go into the categories of children without health insurance, children who were not able to obtain needed health care in the last year, and are the population of children with special health care needs that receive limited to no service. Most of the children in this sub-group receive services from the ER or walk-in clinics for critical but nonemergency need, the visits are generally for a one-time issue. The Community Foundation of the Virgin Islands 2019 Kids Count Handbook, p. 45, "Between 2016 and 2017, the number of children under 18 who received Medicaid benefits increased by almost 77%." However, once a child reaches age 18 and is not a person with Special Health Care Needs a young person is without insurance until they join the military, get a job with insurance benefits. Transition planning includes the Family Planning Clinic, continued services with MCH from ages 15 to 20, 21 is the transitional year from the MCH clinic. Young adults can continue to receive services at MCH and Community Health from age 17 without parental consent. Young adults with Special Needs can continue to receive services at MCH or Community Health

7. Increase access to oral health care for the Maternal Child health population (NOM 14):

MCH clinics have been without dental services for several years. The FQHCs provide pediatric dental services by appointment. Emergency dental care is provided in the ER.

Parents in MIECHV home visiting program are encouraged to identify a dental home for their child from while enrolled in the program. MIECHV supports oral health care by providing toothbrushes for all dental states; stage 1 gum care, stage 2 first teeth care and stage three full tooth brushing with toothpaste. Dental care education is provided to families. Families are encouraged to make the first dental appointment by the child's first birthday and to continue to treat dental care as important as any other child well visit and should be scheduled twice a year at minimum.

MCH will continue to provide dental care education to parents, provide early age appropriate toothbrushing tools and soon add a part-time dental hygienist to provide oral health care education in the schools and clinics.

8. Increase the number of women breastfeeding up to six months (NOM 4)

The number of women in the Virgin Islands who continue to breastfeed to six months is very small. A CQI project undertaken by the MIECHV program indicated that mothers may continue to breastfeed if - One, they do not have to return to work or school. Two they have received appropriate lactation training and understand the importance of breastfeeding to baby's health and development. They are trained in alternatives to support breastfeeding such as pumping and storage of breastmilk. Finally, employer support for maternal health issues and time provided to pump and store breastmilk in the workplace would enhance support to breastfeeding mothers.

MCH programs provide mothers with lactation training, baby bottles, and pumps to support breastfeed and breastfeeding education. While our mothers may not breastfeed to six months the majority of MCH prenatal mothers are provided with breastfeeding education and support tools.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,473,690	$1,488,491	$1,479,815	$1,487,068
State Funds	$1,300,000	$1,300,000	$0	$0
Local Funds	$0	$0	$1,365,388	$1,194,950
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$2,773,690	$2,788,491	$2,845,203	$2,682,018
Other Federal Funds	$1,837,374	$1,143,527	$0	$2,017,947
Total	$4,611,064	$3,932,018	$2,845,203	$4,699,965

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,488,491	$1,493,758	$1,487,068	
State Funds	$0	$0	$1,169,459	
Local Funds	$1,169,459	$1,559,491	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$2,657,950	$3,053,249	$2,656,527	
Other Federal Funds	$2,924,008	$2,564,558	$2,899,791	
Total	$5,581,958	$5,617,807	$5,556,318	

	2022	
	Budgeted	Expended
Federal Allocation	$1,493,758	
State Funds	$0	
Local Funds	$1,169,459	
Other Funds	$0	
Program Funds	$0	
SubTotal	$2,663,217	
Other Federal Funds	$5,715,008	
Total	$8,378,225	

III.D.1. Expenditures

Expenditures

VI MCH Title V Funds in addition to other federal and local funds is obligated and disbursed to support VI MCH demands and priority needs. Budget forms 2, 3a and 3b were prepared to provide a complete set of budget and expenditure data for 2020. Field notes were added to provide added detail to individual form cell as needed.

In 2020, VI MCH received $1,493,758 in Title V federal funding and had a local match of $1,559,491 bringing the total Title V partnership to a total of $3,053,249. This financial narrative corresponds with the budget forms in this application and annual report.

The Title V expenditures for 2020 were classified in the following categories:

Prevention and Primary care for children……(30.1%)
Children with Special Health Care Needs…...(31.8%)
Administrative……...(10.0%)

The U.S. Virgin Islands complies with the maintenance of effort as described in Section 505(a) (4). State funds are used to provide a wide range of services to the MCH population. These services include but are not limited to pediatric, prenatal, high-risk, social services and immunization.

A large amount of Title V funds is used to support the MCH workforce to address the priority needs identified in the Needs Assessment. In 2020 Title V supported salary and fringe cost for MCH employees who provide direct care and administrative support to the program.

In 2020, the program utilized Title V funds to engage in numerous health awareness campaigns. These campaigns educated and encouraged families to engage in healthy behaviors that provide resistance to serious health treats. The health campaigns included development of jingles, radio, tv, social media ads and videos. Title V funds were also used to conduct outreach activities in the territory.

Title V funds were expended to provide additional personal protection equipment (PPE) to the MCH staff to ensure staff and clients are protected when providing care. Funds were also used to equip MCH clinics and offices with automatic hand soap, automatic hand sanitizer dispensers and Infrared thermometers to help stop the spread of Covid-19.

Title V funds also supported preventative and primary child health care, integrated newborn genetic metabolic and hearing screening, prenatal care services and care coordination and audiology services. Funds continue to support prenatal post-partum and inter-conceptual care through our partnership with Family Planning, WIC, Communicable Diseases and Behavioral Health to ensure that our clients receive all the required services needed.

Title V funds supplement other federal programs that falls under the purview of VI MCH and provide service to the MCH population, such as MIECHV, who support evidence-based home visiting and efforts to engage women and families, SAMSHA Project Launch Grant that provides early intervention to the 0-8 population and the Universal Newborn Hearing Screening grant that augments the statewide newborn hearing screening program and supports enhanced efforts to track newborns lost to follow-up services.

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III.D.2. Budget

Budget (Application Year)

Title V along with local funds and other federal funds is used to provide VI MCH clients and the community with accessible family-oriented health services that promote the well- being of children and families. VI Title V funds are administered and managed by the MCH Title V leadership team. The leadership team meets regularly to assure that funds are obtained and used effectively and efficiently in meeting the needs of the VI MCH population. The Title V Director, Assistant Director, Financial Manager and Office Manager makes up the MCH Title V leadership team.

As discussed in the preceding expenditure section, In FY 2022 VI MCH will continue to adhere to the 30/30/10 Title V legislative requirement. This is reflected in Form 2 (lines 1A, 1B and 1 C) in the Application Budgeted for FY 2022 where 30% is designated for preventative and primary care for children, 30% is designated for Children with Special Health Care Needs and 10% for administrative costs. Throughout the fiscal year, to ensure budget and expenditures are on track and to address any new or unplanned needs, the VI MCH financial team conducts regular financial meetings.

2022 Compliance of 30/30/10 Requirement:

Amount requested for BY: 1,493,758

Breakdown:

Preventative and Primary Care for Children	$448,128
Children with Special Health Care Needs	$448,128
Title V Administrative Costs	$149,375

Budget Allocation
No more than 10 percent of VI Title V funds are assigned to administer the grant. The total 10 percent will be used to support salary, fringe benefit, office supplies and equipment for title V staff in charge of managing the financial and administrative aspects of the grant. Funds will also be used for AMCHP and other annual membership dues.

Maintenance of Efforts (MOE)-The VI remains in compliance with the maintenance of effort (MOE) in accordance with Title V Section 505(a) (4). Local funds are provided through direct allocation of VI general and health revolving funds. Maintenance of efforts funds are used to support salary and fringe for Public Health Nurses, Certified Medical Assistants, and Pediatric Providers that provide direct service to VI MCH population. The ongoing ad campaign to continue to provide education to the community about the MCH programs and what they offer is accommodated in the MOE. Medical supplies, equipment, PPE, and other items needed for direct service staff to meet priority needs is also supported through the MOE.

In addition to Title V and local funds, VI MCH receives other federal funding sources, identified on form 2, that contribute to achieving MCH outcomes. The details of the programs are:

- $235,000 for EHDI to develop a comprehensive system of care targeted to ensuring newborns and infants are receiving timely services, including, screening, evaluation, diagnosis, and early intervention.
- $50,000 State Systems Development Initiative (SSDI)
- $975,783 Maternal Infant Early Childhood Home visiting to improve health and developmental outcomes for at-risk children through evidence-based home visiting program
- $550,000 Project Launch to promote wellness of young children ages birth to 8 years by addressing the physical, social, emotional and cognitive aspects of their development
- $1,074,008 Zika Maternal and Child Health Services to support a system of care for babies born to Zika positive mothers and their families

A program income account was established and will be implemented in FY 2022.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Virgin Islands

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Since 1935, the Maternal and Child Health Block grant is the only federal program dedicated to improving the health of women children and families. The Virgin Islands Maternal Child Health and Children with Special Health Care Needs (MCH & CSHCN) program has been serving the territory for decades by providing quality health care to women, infants, children, adolescents, and children with special health care needs.

The Vision of Maternal Child Health Bureau (MCHB), under which the Virgin Islands MCH & CSHCN falls, is for "optimal health and quality of life for all children and youth with special health care needs and their families." In view of this, it is essential to create an efficient and effective system of care that not only addresses the needs of the child, but the family and entire community within which that family resides.

The mission of the VI MCH & CSHCN Program is to provide the clients and community we serve with accessible, family-centered health services that promote the well-being of children and families in an environment that is inviting, courteous, respectful and values patient confidentiality. The MCH/CSHCN Program endeavor to assure that every child has a healthy start by providing access to appropriate services for all pregnant women, mothers, and women of child-bearing age."

Direct Services assures access to preventative and primary health services for infants, young children, and adolescent. Specialty Clinics such as the Zika Health Brigade provide specialty services that are generally unavailable or inaccessible to low-income, uninsured, or underinsured families.

Enabling Services are non-clinical services that allow individuals to access health care and improve health outcomes where Title V funds are used to cover these services. These services include outreach, care coordination, referrals, and health education for individuals and families.

Public Health Services and Systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development and the 10 essential public health services where Title V funds are used to cover these services.

To improve health outcomes for the MCH population, VI MCH address national and state performance measures through coordination of efforts with partners, families, and other stakeholders. To align with the goals of the Title V Block Grant and improve performance VI MCH practices quality improvement efforts and ensures that MCH activities are evidence based and data driven. This allows for improved assessment of all programming to determine changes in health outcome. The Maternal Infant Early Child Homevisiting (MIECHV), Early Hearing Detection Intervention (EHDI) and Project Launch program reside within the VI MCH allowing for advance effective coordination of efforts. Through coordinated efforts, VI MCH endeavors to improve the health of the territory's MCH population, prepare and respond to emerging issues and meet the objectives outlined in the Territory's Action Plan.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

It is the goal of VI MCH to ensure that staff engage in workforce development. The goal of workforce development is to enhance the skills of employees and give them the necessary tools to be successful and competitive in the workplace. VI MCH acknowledges the significance in developing the VI MCH workforce and enhancing MCH capacity at the Virgin Islands Department of Health (VIDOH). To better serve the MCH population, address and adapt to changes in the VI, and to improve health outcomes, the Title V workforce strive to maintain optimal subject matter expertise and staffing infrastructure.

The Maternal Child Health (MCH)and Children with Special Health Care Needs (CSHCN) Division is housed within the Virgin Islands Department of Health. Currently there are six programs under the MCH & CSHCN Division: Title V, Early Hearing Detection Intervention Program (EHDI), the Maternal Infant Early Child Homevisiting (MIECHV), Zika Pregnancy Grant and the CMS Zika Grant. In addition to the six programs, there are two MCH clinics operating within the MCH & CSHCN Division that provides direct care to the MCH population.

The MCH Division is led by the MCH Title V Director. The Director is responsible for the administrative oversight of all programs and clinics under the MCH Division. Each program is administered by a program Manager/Coordinator that reports to the Director. The Title V administrative staff consist of the Title V Director, Office Manager, Financial Manager, Speech Pathologist and Medical Social Worker. The Title V clinical staff consists of two (2) head nurses, six (6) Registered Nurses, four (4) Certified Nursing Assistants, two (2) Certified Medical Assistants and two (2) Data Registration clerks. The EDHI program is staffed with the EHDI Coordinator and two (2) Family Care Coordinators. The MIECHV program houses two homevisting models, Nurse Family Partnership (NFP) and Healthy Families of America (HFA). Each model is staffed with a Nurse Supervisor and two(2) homevisiting nurses and a data administrative personnel. The MIECHV Program Manager oversees the day-to-day functions of the MIECHV program. The Project Launch program currently consist of two staff, a Program Manager and an outreach worker however should be staffed by five employees. There are currently three vacant positions, Outreach Worker-STT, Evaluator and Project Launch Wellness. The CMS Zika Grant has one staff, the Program Manager, and the Zika Pregnancy Grant and the SSDI grant is currently administered by the Title v Director.

The Title V program also support a substantial amount of training. Several Federal grants include workforce development as an intricate part of the program strategy/activity to include:

- MIECHV all grantee meeting for homevisiting staff
- EHDI Annual conference for EHDI coordinator
- Title V supports AMCHP conference

MCH program managers participated in an online Fundamental of Supervision and Management ll Training offered by the University of the Virgin Islands. In the course, managers learned how to be a more effective managers and master the basics of communication. Effective communication is essential in the quest to be a good manager. Team leads also learned how to develop interpersonal skills by understanding and dealing with the various people issues that arise at work. Staff were also engaged in a MCH Professional Development Day geared towards the importance of self-care especially working in the healthcare arena during these unprecedented times.

There are currently barriers that are affecting the hiring of staff needed to carry out the mission efficiently and effectively of VI MCH & CSHCN. Recruitment and retention are the primary reason. MCH continue to work with the Human Resources Division at Department of Health to ensure that qualified staff is hired and to reduce employee turnover and increase morale in the MCH Division.

III.E.2.b.ii. Family Partnership

The Maternal and Children Health Division understands and identifies the benefits that comes from collaboration with families. Strengthening family partnership remains a key priority and area of focus for VI MCH. Family partnership is important at all stages of healthcare improvement. It is the intent of VI MCH to develop stronger partnership with families, strengthen system of care and improve health outcomes for the MCH population.

MCH depends on a variety of mechanisms to capture family voice. A series of outreach activities were conducted to engage families. Title V collaborated with other DOH Divisions, the Department of Education, Head Start, and other community partners and held a series of community outreach activities for families. The activities included the Oral Health Month, Nutrition Month, Mental Health Month and the MCH Back to School community outreaches. The activities provided education and encouraged families to lead a wholistic healthy lifestyle. They also foster family engagement and serves as a strategy to recruit families to join the MCH advisory and other committees geared towards strengthening family partnerships within the MCH Division.

Continuous family engagement occurs within the MCH programs such as the Maternal Infant Early Childhood Homevisiting (MIECHV), Early Hearing Detection Intervention (EHDI), VI Project Launch and the MCH public health clinics. VI MCH was successful in hiring its first family representative as an EHDI Family Care Coordinator. Three parents joined the MCH Title V Advisory Board in 2020. The Project Launch program held virtual cafes and parent representatives had the opportunity to conduct their own cafes. Parent cafes are parent community groups in which parents share learn and find support.

VI MCH conducts a monthly diabetic clinic for families with children diagnosed with diabetes. It is a multidisciplinary clinic that provides diabetic education on carbohydrate count, increase activity to decrease the need for insulin and proper hygiene. Participants include families, school nurses, a representative from school lunch services and physical education teachers.

MCH engages families across the territory at meetings, community events, health fairs, and workshops. Partnership with other government agencies, community partners and other DOH programs help support MCH initiatives and strengthen opportunities for meaning collaborations with families. MCH is committed to involving youth and families in our program initiatives. Parents, youth, and young adults are invited to join VI MCH health initiatives to share knowledge and experience, develop strategic goals and objectives and learn about best practices from MCH staff and other families. As we continue to promote awareness, our goal is to increase support and improve health for the MCH population.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

A goal of VI MCH is to ensure adequate and increasing state capacity for advancing the health of the MCH population. MCH is currently pursuing the addition of an epidemiologist to the MCH workforce as we continue to focus on improving the health of women of childbearing age and all children between the ages of 0-21. This will allow us to build capacity and improve the overall health of mothers, children, and families in the territory. As funding is identified, recruitment will begin to hire a qualified epidemiologist.

VI MCH recommended Ms. Yvonne Thomas, a current MCH employee, for the Training Course in MCH epidemiology. Ms. Thomas was selected from a competitive field of over 200 applicants to participate in the training course. She has successfully completed the course and received her certificate.

The Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), and CityMatCH offered the course Training Course in MCH Epidemiology as part of their ongoing effort to enhance the analytic capacity of state and local health agencies. The training course is an intensive program, combining lectures, discussion, hands-on exercises, and opportunities for individualized technical assistance.

VI MCH will pursue further collaboration with the Maternal Child Health Epidemiology Program to continue to build capacity.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The purpose of the State System Development Initiative (SSDI) grant in the USVI is to complement the Title V MCH Block Grant through the objectives and activities supporting the three specific goals.

The goals are:

- Expand state and jurisdictions' MCH data capacity by utilizing Title V/MCH data analytic support to assist with AIM QI efforts and enhance data-driven decision making to improve maternal health care.
- Support the State's quality improvement efforts through improved availability and reporting of timely data to track outcomes that drive
- Enhance the collection and use of data on race, ethnicity, and social determinants to assess the impact of the AIM program on health equity and health disparities.

Goal 1. Build and expand State MCH data capacity to support Title V program efforts and contribute to data-driven decision-making in MCH programs. The program activities are:

- Data support in conducting on-going MCH program needs assessment, including the State's Title V program's five-year Needs Assessment.
- Yearly submission of the State's Title V MCH Block Grant Application and Annual Report.
- Identification of structural and process measures to address the National Performance Measures (NPMs) selected by the State for its Title V program; and
- Development of State Performance Measures (SPMs) to address the identified State Title V program priority needs to the extent that the NPMs do not manage them.

Goal 2. Support the State's quality improvement efforts through improved availability and reporting of timely data to track outcomes that drive quality improvement and collaborative learning. The SSDI program activities for the reporting period are as follows:

Program Activities:

- Provided support in developing NPMs, SPMs, and ESMs for the 2022/2020 Title V Block Grant Application/Annual Report. (Goal 1).
- Analyze MCH jurisdictional survey data and used as applicable for the 2022/2020 block grant application report
- Shared quality improvement data efforts representing the VI on the MCH jurisdictional survey (such as @ AMCHP)
- Represented the VI at the 2020 AMCHP conference and provided quality improvement support on the MCH Jurisdictional Survey data (1)

- Continued to work on data quality improvement with MCH clinical staff and program leads ensuring progress on Title V program performance measures and strategies (Goal 2).

- SSDI staff provided data support for the Title V Block Grant and Maternal Infant Early Homevisiting (MIECHV) Program continued Needs Assessment as appropriate (Goal 1)

- SSDI provided data support that led to the creation of a Covid-19 educational program encouraging parents to get their children 12 and older vaccinated. The product developed was a vaccine jingle and video broadcast on social media platforms as well as radio and television. (Goal 1)

- SSDI supported the development of a Covid 19 brochure to providing education to pregnant moms using MCH data. (Goal 1)

- Enhance data capacity through SSDI program Staff participation in the Training Course in MCH Epidemiology. VI-SSDI was selected from a competitive field of over 200 applicants. The training included courses such as Analytical Approaches for Performance Measures, Needs Assessment Overview and Key considerations, Perinatal Periods of Risk (PPOR) Phases I and II, Relative absolute, and measures of impact, Multivariable Analysis Approaches, Evaluation and Data Communication to Non-Academic Audiences. (Goal 1)

- Enhanced capacity through contracting with the University of the Virgin Islands (UVI) Caribbean Exploratory Research Center (CERC) Program to assist with sections of the Block Grant which requires the presentation of data to support the 2020/2022 application. (Goal 1)

1. Specifically, UVI CERC updated data from the 2020 Title V Block Grant Application related to, demographics, Economic Factors, Community Economic Factors and Socio-Economic Factors.
2. Support the data needs of the 2021 Title V Block Grant application by using data provided by VIDOH through its MCH & CSHCN Program, its Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, its WIC and Family Planning Programs to complete data analysis to support tables that are included within the body of the grant application, specifically:

    A. Table(s) that captures local indicators linked to National Outcome Measures (NOMs)

    B. Table(s) related to evidence-based or evidence-informed Strategic Measures (ESMs)

    C. Table(s) related to state performance measures (SPMs)

    D. Table(s) related to national performance measures (NPMs). MCH also contracted with the University of the Virgin Islands (UVI) CERC to complete the 2020 Title V and the Maternal Infant Early Homevisiting (MIECHV) Needs Assessment.

VI SSDI continues to effectively gather data through in-house data systems as well as effective linkages to other systems that serve the MCH population. It is the goal of the SSDI to ensure the continued effectiveness and readiness of VI MCH Title V-supported programs in responding to the changing needs of the MCH population.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

The Maternal Child Health & Children with Special Health Care Needs (MCH &CSHCN) Program contracted The Caribbean Exploratory Research Center (CERC) at the University of the Virgin Islands (UVI) to complete sections of the Title V Block Grant Application which requires the presentation of data to support the Title V Block Grant application.

Specifically, UVI CERC updated data from the 2020 Title V Block Grant Application related to:

1. Demographics
    a. Overall population
    b. Youth population (18 and under)
    c. Race and Ethnicity
    d. Languages spoken at home
    e. Population by nativity/citizenship
2. Economic Indicators
    a. Median Income
    b. Cost of Living Indicators
    c. Poverty Status
3. Community Economic Factors
    a. Unemployment
    b. Status of Private Businesses
    c. Government Revenues
4. Socio-economic Factors
    a. SNAP and TANF families
    b. Children in Families
    c. Health Insurance
    d. Medicaid
    e. Poverty level
5. KidsCount Data
    a. Child and Family Demographics
    b. Indicators of V.I. Children's Well-being

Additionally, CERC supported the data needs of the 2021 Title V Block Grant application by using data provided by VIDOH through its MCH & CSHCN Program, its Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, its WIC and Family Planning Programs to complete data analysis to support tables that are included within the body of the grant application, specifically:

1. Table(s) that captures **local indicators** linked to National Outcome Measures (NOMs)
2. Table(s) related to evidence-based or evidence-informed Strategic Measures (ESMs)
3. Table(s) related to state performance measures (SPMs)
4. Table(s) related to national performance measures (NPMs)

Finally, CERC supported the data needs of the 2021 Title V Block Grant application by using data provided by VIDOH through its MCH & CSHCN Program, its Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, its WIC and Family Planning Programs to complete data analysis to support Forms that are included as Appendices to the grant application, specifically:

1. Form 4: Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated
2. Form 5: Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V and Form 5b: Total Percentages of Populations Served by Title V
3. Form 6: Deliverables and Infants Served by Title V and Entitled to Benefits Under Title XIX
4. Form 10: National Outcome Measures (NOMs) [all relevant NOMs]
5. Form 10: National Performance Measures (NPMs) [all relevant NPMs]
6. Form 10: State Performance Measures (SPMs) [all relevant SPMs]
7. Form 10: Evidence-Based or Evidence-Informed Measures (ESMs) [all relevant ESMs]

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The Virgin Islands (USVI) Territorial Emergency Plan (TEOP) is led by the Virgin Islands Territorial Emergency Management Agency (VITEMA). The purpose of the TEOP is to establish the overall framework within which all entities of territorial government, non-governmental organizations, private sector, and the citizens of the territory will operate in an integrated and coordinated fashion before, during and after a disaster. The TEOP is currently undergoing revision and should be completed by December 2021.

The Department of Health (DOH) is the lead agency of the Emergency Support Function 8: Public Health and Medical Services Plan (ESF-8) of the VI TEOP. The ESF-8 plan is the guide for public health and medical emergency response and recovery operations, outlining specific actions in support of VIDOH, hospitals, emergency medical services, long-term care facilities, and health and medical centers, to support response and recovery activities.

The Health Commissioner leads and directs the USVI Department of Health (DOH) emergency response organization. As the ESF-8 lead, Department of Health operates its own Emergency Operations Center (EOC). MCH staff currently holds critical roles in the DOH EOC. The Title V Director and the MCH Clinic Head Nurses are a part of the leadership structure in the DOH Emergency Operations Center. The Title V Director holds the Operations Manager position for the STT/STJ District, and the Head Nurses are the nursing leads in the Special Needs Shelter.

DOH operations must be performed efficiently with minimal disruption, especially during an emergency. The *USVI DOH Continuity of Operations (COOP) Plan* provides planning and program guidance for continuing DOH mission essential functions (MEFs) and critical tasks under all threats and conditions. VI MCH was involved in the development of the USVI Coop Plan.

The MCH (EOC) staff participated in a EOC specific position training. The purpose of this training is to familiarize participants with the roles and responsibilities of multiple EOC positions including Incident Command and Section Chiefs (Planning, Logistics, Operations, Finance/Admin). Through a mixture of plenary sessions and activities, participants will improve their ability to support an EOC activation. The training will culminate in a simulated emergency requiring EOC activation where participants can put into practice the knowledge and skills gained during training.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

VI MCH maintains that direct services are offered through Title V when no other coverage is available. Title V funded programs that include direct clinical care benefits to clients provide information on available local and federal resources that can help meet their health care needs. As the payor of last resort, it is important that MCH ensure that clients served were not covered or reimbursed through another provider. A memorandum of agreement was established between the Medical Assistance Program (MAP) and the Maternal and Child Health Division for the purpose of providing rapid access to quality health care service to the MCH population.

VI MCH has developed a long-standing relationship with the territory's hospital to conduct hearing screenings to all newborn babies in the territory. The EHDI program goes into the hospitals daily to screen newborn babies for hearing. If babies are missed, the nursery provides the contact information for EHDI so families can schedule an appointment to come to MCH.

Effect of Coronavirus on the territory's infrastructure

The coronavirus pandemic has been disruptive for all and sadly, devastating, and difficult for many. As of August 19, 2021, there have been 5,594 Covid-19 confirmed cases and 45 deaths in the territory.

With the health care system focused on testing and treating the coronavirus, adaptations in care delivery were made quickly with patients and multiple avenues was provided for access to care while it was unsafe or impossible for patients to come to clinical spaces. Telemedicine has emerged as a viable option to provide treatment while protecting the clinical staff and clients.

The U.S. Virgin Islands is reinforcing critical public health messaging like symptom monitoring infection prevention and ways to avoid the spread of disease into our territory. By following the health department's guidance, Virgin Islands residence can keep themselves and families safe if they encounter someone with Covid-19 or other viral respiratory pathogens like the flu.

The VI have engaged in a series of campaign to stop the spread of Covid-19. The Governor's office has implemented several Covid-19 vaccine incentives to encourage families to take the Covid-19 vaccine to stop the spread.

VI Health Care Facilities

The United States Virgin Islands has an organized primary/preventative and public health system. There are two main hospitals, one located on the island of St. Thomas and one on the island of St. Croix. The Myrah Keating Smith Community Health Center located on the island of St. John serves the $5,000 St. John residents.

Families and children of the USVI can address their health care needs through several different facets of the USVI healthcare system. The selection made by families may be influenced by level of income, access to transportation, level of education and language barriers. The healthcare systems of the VI which must address the needs of the community consist of the Virgin Islands Department of Health (VIDOH), the Federally Qualified Health Centers (FQHCs), Frederiksted Health Center, Inc. (FHC) on St. Croix and the St. Thomas East End Medical Center (STEEMCC) on the island of St. Thomas: two hospitals, the Juan F. Luis Hospital and Medical Center (JFL) and the Schneider Regional Center (SRMC), many private providers and 382 licensed medical professionals (excluding nurses).

Roy Lester Schneider Regional Medical Hospital (RLS)

The Roy Lester Schneider Hospital is a 169-bed acute care facility located on St. Thomas, United States Virgin Islands. Since 1982, it has served the residents of St. Thomas and nearby St. John, St. Croix residents who have required its services, as well as 1.2 million visitors who arrive by air and cruise ships each year. Meeting the health care needs of its community has required constant expansion of medical services, and recruitment of highly qualified and board-certified medical professionals.

The hospital is a popular provider of choice for the USVI community, and, given the services now offered, it is the convenient option for many patients from throughout the Eastern Caribbean region who are referred here for treatment.

The Myrah Keating Smith Community Health Center is a comprehensive primary healthcare facility located on St. John, For residents and the thousands who visit each year, the center provides 24-hour emergency services and outpatient clinics Monday through Friday. Myrah Keating Smith Community offers high-risk OB/GYN, well woman examinations including PAP smears, complete pelvic exams, pre and post-natal care. The facility is staffed to provide many other services, including adult medicine, pediatrics, radiology, ophthalmology, laboratory, and nutrition counselling.

Juan F. Luis Hospital and Medical Center (JFL)

The Governor Juan F. Luis Hospital and Medical center (JFL) is composed of the Governor Juan F. Luis Hospital, the only hospital on the island of St. Croix, and the Virgin Islands cardiac center. JFL offers general inpatient and emergency care, behavioral assessment and outpatient diagnostic services (laboratory, radiology). The Interventional Cardiology services are no longer available.

In 2018 Juan Luis hospital was operating at 50 percent capacity. In 2019, JFL capacity increased to 52 and will increase to 80 by the summer of 2020. In December of 2019 JFL began accepting dialysis patients credited to the new modular dialysis trailers the hospital received. JFL received the full modular hospital which includes a four modular operating room.

Federally Qualified Health Centers (FQHCs)

The Territory has two Federally Qualified Health Center, St. Thomas East End Medical Center Corporation, Inc. (STEEMCC) in the STT/STJ district and Frederiksted Health Center (FHC) in the St. Croix.

STEEMCC provides comprehensive primary health care service on the Eastern end of the island on St. Thomas. They offer primary health care services in behavioral health, family planning, women's health, men's health, obstetrics, pediatrics, senior care, adult and pediatric dental care and nutrition services. Screenings are also provided for blood pressure, cholesterol, glucose, TB and breast, cervical and prostate cancer.

Frederiksted Health Center operates five sites on the island of St. Croix. Three sites offer comprehensive primary care services, Ingerborg Nesbitt Clinic, the first service site, on Strand Street, Frederiksted; North Shore site in La Grande Princess; Christiansted; and one mid-island at Sion Farm Shopping. One satellite clinic is based at the St. Croix Educational Complex, a public high school and the fifth site offers. Services provided at primary care clinics include medical, behavioral health and dental care, and serve all ages, from prenatal to the elderly.

It is extremely important that the FQHCs are strategically located and accessible by public transportation and focus on providing primary care to low-income families who fall below the federal poverty level and reside in medically underserved communities. USVI vulnerable population benefit from the wide range of payment options offered by the FQHC's, including offering a sliding fee scale and accepting patients covered through private insurance, Medicaid, Medicare, and self-payment.

Virgin Islands Department of Health (VIDOH)

The Department of Health functions as both the state regulatory agency and the territorial public health agency for the U.S. Virgin Islands. As set forth by the Virgin Islands Code, Title 3 and 19, the Department of Health (DOH) has direct responsibility for conducting programs of preventative medicine, including special programs in Maternal Child Health, Family Planning, Environmental Sanitation, Mental Health and Drug and Substance Abuse Prevention. Many services and programs provided by the VIDOH through their public health clinics are used by families and children in the territory. The VIDOH clinical services offered to the USVI community include Maternal and Child Health (MCH), Community Health, HIV/STD, and the Women Infant and Children program (WIC). DOH is also responsible for health promotion and protection, regulation of health care providers and facilities, and policy development and planning, as well as maintaining the vital statistics for the population.

Department of Health provides Emergency Medical Services, issues birth and death certificates, perform environmental services and conducts health research and surveys. The Department is also responsible for regulating and licensing health care providers and facilities and assumes primary responsibility for the health of the community in the event of a disaster.

In 2019, a modular version of Department of Health's Charles Harwood Complex (CHC) opened. Due to major damages cause by the 2017 hurricanes, the complex closed in 2018. The modular is a parred down version of the CHC and houses the entire DOH St. Croix programs, services, and clinics.

STATEMENT OF AGREEMENT

TO ENSURE MAXIMUM COLLABORATION AND UTILIZATION OF THE NEEDSPROGRAM UNDER THE VIRGIN ISLANDS STATE PLAN FOR MEDICAL ASSISTANCE, TITLE XIX OF THE SOCIAL SECURI1Y ACT.

1. **INTRODUCTION:**

As of this date, June 12, 1995, the Agreement between the MEDICAL ASSISTANCE PROGRAM (MAP) and the MATERNAL AND CHILDHEALTH AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM (MCH & CSHCN) is updated to reflect both new Federal requirements and new programsand services in the Virgin Islands.

The purpose of this document is to record an agreement between the MAP Single State agency and the Maternal and Child Health and Children With Special Health Care Needs Program, and to implement provisions of Section 1902 (a) (11) (a) of the Social Security Act. Federal Regulations require written agreements between Title XIX, State Health Agencies and Title V, Public Health Services and clearly establish the working relationships and respective duties of the agencies involved.

2. **MUTUAL RESPONSIBILITIES**

1. Coordination, strengthening, development and implementation of medical care services rendered toChildren With Special Health Care Needs and otherneedy children up to 21 years of age, and mothers.

2. Development of a Joint MAP/MCH Utilization Review Committee to consider amount, duration, scope, and quality of care service provided. Committee membership will include representatives from Division of Maternal and Child Health and Children With Special Health Care Need, and MAP.The committee will also make recommendations as to the improvement of the delivery of health services.

3. Establishment of effective working arrangements whereby the best utilization is made of manpower and other resources available in rendering services for the benefit of the child's mother.

3. Development of an orderly referral system and follow-up services. Conduct studies to ascertain and determine the effectiveness of the working agreement, patterns for continuedcollaborative efforts, the quality of the specific services rendered, and to identify unmet needs and make recommendationsregarding ways of meeting those needs.

4. Inform respective applicants and recipients of the specific services available to them, and the procedures under which needed services can be obtained under the Maternal and Child Health and Children With Special Health Care Needs Program andthe Medical Assistance Program.

5. Confidentiality of information shall be maintained and safeguarded according to state Plan and Departmental requirementsand regulations.

6. Through periodic evaluation by a committee representative of staff of Medical Assistance, Maternal and Child Health and ChildrenWith Special Health Care Needs, the quality of duration and scope of services rendered will be reviewed.

III THE MEDICAL ASSISTANCE PROGRAM (MAP)

1. Eligibility of medical assistance is determines at the Certification Unit, Bureau of Health Insurance and Medical Assistance. An MAP card isissued to each eligible recipient and is to be presented at the time services are rendered at the Maternal and Child Health and Children With Special Health Care Needs Program. For the purposeof those individuals who are referred by the clinics who do not present a MAP card and might be eligible, the Statement of Facts (See Attachment #1) will be provided by the Medical Social Workerand an appointme_nt will be made for certifications.

2. The Medical Assistan·ce Program will make available to eligible recipientsmedical treatment and other health services normally or usually provided by the Maternal and Child Health and Children **With** SpecialHealth Care Needs Programs. Medical services and care such as inpatient care, outpatient care, appliances, prostheses and other adaptive equipment will be among those services agreed upon for funding by Title XIX under the conditions specified in the agreement.

3. If needed medical and health services are not available for eligiblerecipients in the Virgin Islands, the Medical Assistance Program will arrange for off-island travel to Puerto Rico or the Continental U.S. (See Attachment #2) Such specialized services are based on the completion of a referral form signed by the physician, and countersigned by the Director of the referring program, such as Pedia trics, Community Health , Maternal and Child Health and Children With Special Health Care Needs Program and approved bythe Medial Assistance Program's Medical Consultant.

4. Medical Assistance agrees to the funding of medical care and servicesfor recipients also eligible under the Maternal and Child Health and Children With Special Health Care Needs Program for conditions not related to primary diagnosis (non-crippling illness), when such conditions are covered under the approved Title XIX plan.Necessary information will be submitted officially to the Medical Assistance Program by the Maternal and Child Health and Children WithSpecial Health Care Needs Program.

4. MATERNAL AND CHILD HEALTH AND CHILDREN WITH SPECIAL HEALTHCARE NEEDS PROGRAM.

A The Maternal and Child Health and Children With Special HealthCare Needs Program shall be responsible for early case findings, identification, registration and treatment of children with cripplingand potentially crippling conditions.

2. The Maternal and Child Health and Children With Special Health Care Needs Program shall be responsible for the provision of preventive and diagnostic health services for mothers, infants, and for children upto 21 years of age.

3. The Maternal and Child Health and Children With Special HealthCare Needs Program shall be responsible for the provision of treatment services related to crippling and potentially crippling conditions of children up to 21 years.

4. The Maternal and Child Health and Children With Special Health Care Needs Program shall notify Medical Assistance of aggregate screening findings and shall maintain comprehensive clinic records.

available for Medical Assistance review and audit as needed.

V. SERVICES

1. For care in the Virgin Islands, the MAP card will be used for billing purposes at the treatment site. The provider of services will be responsible to see that the recipient has a valid MAP card.

2. For off-island care the services must be pre-authorized by Medical Assistance after review and approval of the referral by the MedicalAssistance Program Medical Consultant. The Medical Assistance program will make all the necessary arrangements for medical, hospital appointments and travel, involving the patient and needed escort.

VI. PRENATAL SERVICES TO ELIGIBLE WOMEN

MAP will provide coverage for all pregnant women that meet the eligibility guidelines from the date of verification of pregnancy. Any woman eligible for and receiving medical assistance while pregnancy-related and post-partum services through the end of the month in which the 60 days post-partum period ends.

Staff will be utilized in Outreach Programs designed to encourage pregnant women to seek health care early in pregnancy. Emphasis will be placed adolescent outreach, and pregnant teenagers, low-income women, and high **risk pregnant women.**

These Outreach Programs will be coordinated with existing resources such as the Rural Health Outreach Program, Deliver Your Best, Answer, and Civic and Community Groups.

1. MATERNAL AND CHILD HEALTH AND CHILDREN WITH SPECIAL HEALTHCARE NEEDS PROGRAMS (MCH & CSHCN)

1. Develops contents, recommends frequency and standards of screening and follow-upservices.

2. Insures availability of services for all eligible children at a projected minimum of 80%per year utilization rate.

3. Performs the required screening se rvices as outlined below on all Medical AssistanceProgram children identified apd interprets the screening results to families.

Health and Developmental History

Comprehensive physical and Developmental ExaminationUrinalysis

Immunization as appropriate for the ageSickle Cell testing

Nutritional AssessmentTuberculin

testing Vision testing

Anemia testing

Laboratory procedures as appropriateSpeech and Hearing testing

Dental Services for all children over 3 years

·CLOS ING STATEMENT

Representatives of the Bureau of Health Insurance and Medical Assistance and Maternal and Child health and Children With Special Health Care Needs Programs enter into this Agreement with the mutual objectives of achieving both the best quality of care for Medical Assistance recipients and the maximum use of existing services. .

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10/9/95

Ma.vi L Matthew;MD,MPH, Director
Maternal and Child Health and Children With Special Health Care**Needs Program**

Priscilla Berry, Director
Bureau of Health Insurance andMedical Assistance

Date

Nathalie George-McDowell, M.D.
Commissioner of Health Designee

Datd /

10/9/95

Date

ed)

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

Since 1935, the Maternal and Child Health Block grant is the only federal program dedicated to improving the health of women children and families. The Virgin Islands Maternal Child Health and Children with Special Health Care Needs (MCH & CSHCN) program has been serving the territory for decades by providing quality health care to women, infants, children, adolescents, and children with special health care needs.

The Vision of Maternal Child Health Bureau (MCHB), under which the Virgin Islands MCH & CSHCN falls, is for “optimal health and quality of life for all children and youth with special health care needs and their families.” In view of this, it is essential to create an efficient and effective system of care that not only addresses the needs of the child, but the family and entire community within which that family resides.

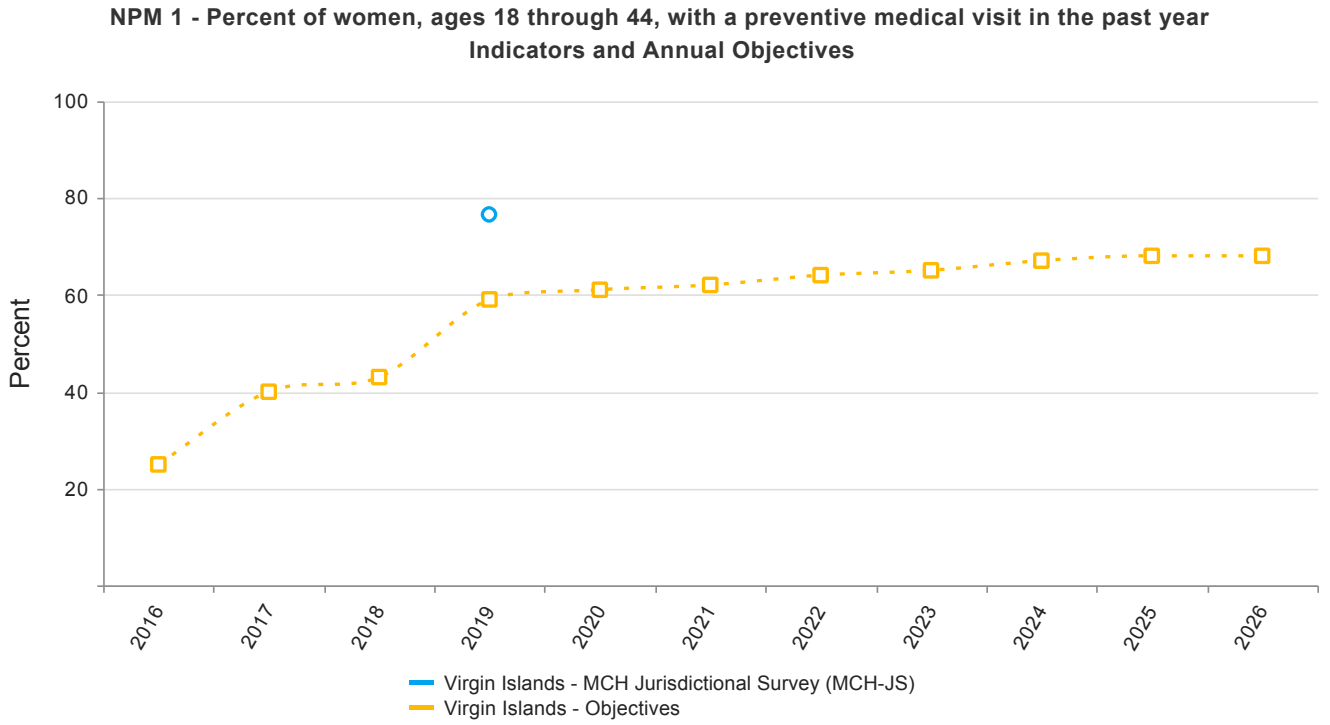
The mission of the VI MCH & CSHCN Program is to provide the clients and community we serve with accessible, family-centered health services that promote the well-being of children and families in an environment that is inviting, courteous, respectful and values patient confidentiality. The MCH/CSHCN Program endeavor to assure that every child has a healthy start by providing access to appropriate services for all pregnant women, mothers, and women of child-bearing age.”

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	MCH-JS-2019	14.6 %	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	9.9 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	MCH-JS-2019	15.1 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	10.2 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	32.0 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	10.0	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2012	Data Not Available or Not Reportable	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	25.4	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	MCH-JS	Data Not Available or Not Reportable	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		61
Annual Indicator	76.6	76.6
Numerator	14,873	14,873
Denominator	19,410	19,410
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	25	40	43	59	61
Annual Indicator	38.5	55.2	57.9	76.6	76.6
Numerator	2,275	2,992	2,986	14,873	14,873
Denominator	5,903	5,419	5,154	19,410	19,410
Data Source	Family Planning and FQHCs	Family Planning and FQHCs	Fam. Planning and FQHCs	MCH-JS	MCH-JS
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	62.0	64.0	65.0	67.0	68.0	68.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percentage of women in Title X sites receiving preconception services.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		41	43	89	89
Annual Indicator	40.6	47.4	87.4	35.8	87.9
Numerator	1,087	1,193	1,579	842	2,587
Denominator	2,677	2,516	1,806	2,349	2,943
Data Source	Family Planning	Family Planning	Family Planning	MCH	Family Planning
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.0	91.0	92.0	92.0	92.0

State Performance Measures

SPM 1 - Increase the percentage of pregnant women who enroll in prenatal care in the first trimester.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			58	50	50
Annual Indicator	57.2	49.9	46.8	59.2	60.2
Numerator	667	487	457	660	586
Denominator	1,167	975	976	1,114	974
Data Source	Hospitial Liaison Nurse Report	Hospital Liaison Nurse Report	Hospital Liaison Report	Hospital Statistics and MCH	Hospital Liaison Nurse and FQHC DataReport
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	51.0	50.0	52.0	54.0	54.0	65.0

State Outcome Measures

SOM 1 - Percentage of pregnant women who receive prenatal care beginning in the first trimester

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	85.5	
Numerator	1,674	
Denominator	1,958	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.5	90.0	91.0	92.0	93.0	93.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Women/Maternal Health - Entry 1	
Priority Need	
Increase the number of women that have well women visits	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
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	
Strategies	
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 by partnering with Title X to conduct provider training	
ESMs	**Status**
ESM 1.1 - Percentage of women in Title X sites receiving preconception services.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Virgin Islands) - Women/Maternal Health - Entry 2

Priority Need

Increase the number of women that have well women visits

SPM

SPM 1 - Increase the percentage of pregnant women who enroll in prenatal care in the first trimester.

Objectives

Emphasize the importance of regular well women visit focusing on self-breast exams, annual gynecological evaluations

Strategies

Improve pregnancy and birth outcomes by providing information/facilitation and access to care

State Action Plan Table (Virgin Islands) - Women/Maternal Health - Entry 3

Priority Need

Increase the number of women that have well women visits

SOM

SOM 1 - Percentage of pregnant women who receive prenatal care beginning in the first trimester

Objectives

Encourage more and better quality contacts between women and health care providers

Strategies

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

Improving the domain of women/maternal health is crucial to VI MCH. We recognize that the selection of National Performance Measure #1 – well women visits is important to increasing healthy births and improving women's health in the VI. For younger women, well-visits can provide a good understanding of a woman's reproductive health. For older women well-visits can help towards the transition to menopause in their later years.

VI MCH have proven that increasing women's health is a major priority. The relationship of risk factors such as diet, physical lifestyle, stress, and health behaviors influence one's health throughout life. Some risk factors can't be changes such as genes and ethnicity. However, we continue to encourage women to engage in healthy behaviors for those risks factors that are within our control such as diet and physical activity.

Health education is important to improve maternal and children's outcomes. To increase awareness of breast cancer, MCH collaborated with the Department of Education and Family Planning and distributed a care package that contained a breast cancer brochure, prophylactics, a mask, and hand sanitizer to Educators. The breast cancer awareness brochure was developed by the MCH Division and contained information about breast health, the importance of regular well visits, annual mammograms, and other information. Family planning supplied the prophylactics.

In the inception of the Covid-19 pandemic there were major concerns around the risk of pregnant women testing positive for the virus. Pregnant and recently pregnant women are at a higher risk for severe illness from Covid-19 than nonpregnant women. Additionally, pregnant women with Covid -19 are at a higher risk for preterm birth and is at a higher risk for other adverse pregnancy outcomes. In 2020, VI MCH conducted outreach and distributed covid 19 brochures, hand sanitizer and masks across the territory. The brochure provided Covid 19 education around pregnant women and women who are still breastfeeding. Over 500 brochures were distributed territory wide. MCH also created a corona virus ad that focused on a child concerned about her pregnant mom contracting the coronavirus and the safety of her new baby sister. The ad encouraged pregnant mothers to stay at home and if they must go outside wear a mask and sanitize. The ad was aired on radio stations across the territory and became very popular.

VI MCH has promoted evidence-based strategies to increase preventative medical visits including the Maternal Infants Early Child Homevisiting (MIECHV) program and the Project Launch program. MIECHV services were not interrupted when the state of emergency was declared due to the onset of the Covid 19 pandemic in March 2020. The MIECHV program immediately switched to virtual visits and continued to provide services to at risk pregnant women in the territory. Our Project Launch program continues to work with the MIECHV program and MCH clinics to support maternal women behavioral health needs. The project launch program accepted referrals to support maternal mothers. MIECHV referred six (6) mothers to the Project Launch program for behavioral health services.

Good Health should be a priority. However, it can be difficult for many women who lead busy lives to take the time to stay on top of their health and well-being. Women's health can be addressed more effectively through joint efforts. MCH intend to enhance partnerships with Family Planning, WIC, Medicaid, Behavioral Health, and Chronic Disease to provide wholistic healthcare to women beginning with early intervention.

Historically women have faced challenges accessing and affording health care and as care givers women often are gatekeepers for family health. Healthy mothers have healthier babies. Appropriate maternal and reproductive health services save money by averting more costly health problems down the road.

VI MCH will collaborate with WIC to encourage peer education and provide breastfeeding support for new mothers. Women who breastfeed have a lower risk for depression. Studies have shown that women who breastfeed seems less likely to develop post-partum depression. Postpartum depression compared to mothers who wean early or do not breastfeed. Breast milk keeps babies healthy. Breastfeeding also helps defend against infections, prevent allergies, and protect against a number of chronic diseases. The American Academy of Pediatrics recommends that babies be breastfed exclusively for the first six months, beyond that breastfeeding is encouraged for up to 12 months and longer once baby and mother are willing.

VI MCH will intentionally foster the relationship with the Chronic Disease Division. Partnership between MCH and Chronic disease is inevitable. Maternal and child health issues are recognized as being indivisibly connected to chronic disease prevention and control. The link is forged during pregnancy and the postpartum period, when health care providers could screen and treat mothers for chronic diseases such as diabetes, poor nutrition, and smoking. However, the connection is more than just the obvious. The work brings increases awareness to early intervention's importance and its effects for lifelong health. Also, expertise from diverse fields, such as tobacco control, nutrition, and diabetes, is needed to adequately address maternal and child health.

The MCH Division will continue to collaborate with the Family Planning program to encourage preconception health. Preconception health and healthcare are necessary for all people of reproductive age. Preconception health provides opportunities to promote women's health before they become pregnant through improved access to care.

Health is an important factor that contributes to human well-being and economic growth Making healthy food choices and exercise play a key role when it comes to overall health and well-being. They are also key contributors to weight management, mental illness, diseases and more. While the importance of diet and exercise is vitally important, preventative care is another important factor in staying on top of your health. Because women represent the cornerstone of a family's overall health ensuring that they have access to quality care can also lead to improved health for children and families.

Perinatal/Infant Health

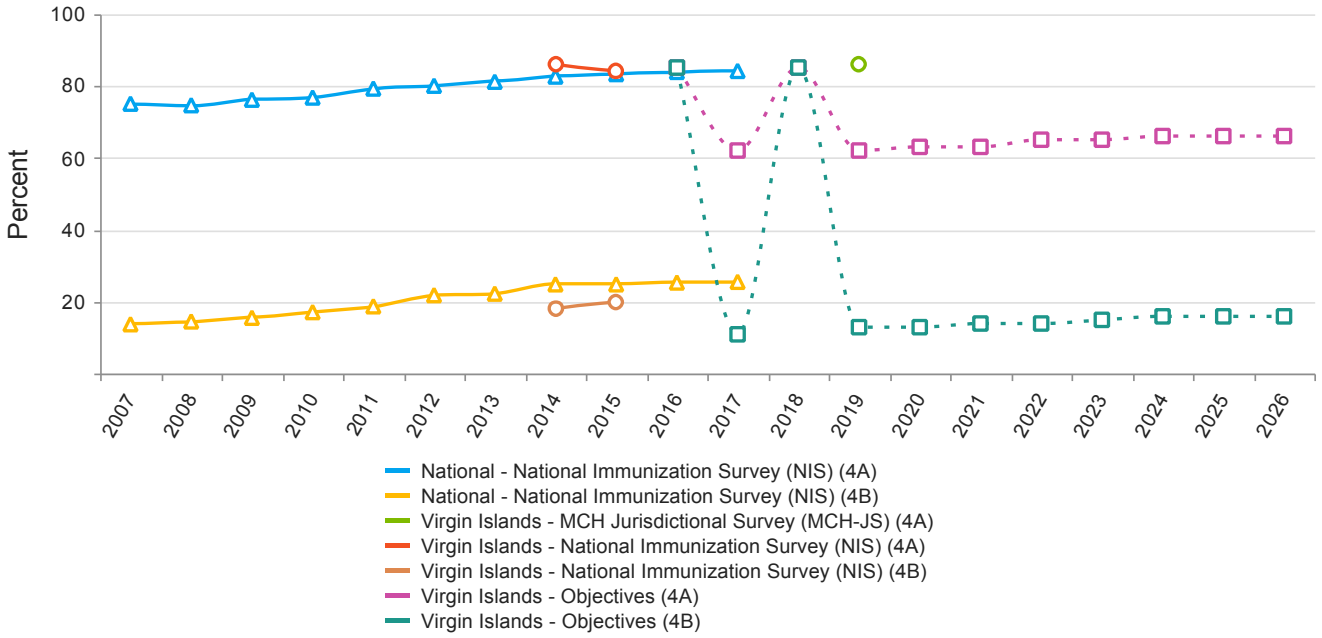
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 4 NPM 5

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	62	85	62	63
Annual Indicator	85.9	83.9	83.9	83.9
Numerator	1,021	880	880	880
Denominator	1,189	1,048	1,048	1,048
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2015	2015

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	62	63
Annual Indicator	86.0	86.0
Numerator	7,734	7,734
Denominator	8,989	8,989
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	85	62	85	62	63
Annual Indicator	61.6	50.8	61.2	19.7	19.7
Numerator	597	423	398	971	971
Denominator	969	832	650	4,925	4,925
Data Source	WIC	WIC	WIC	WIC	WIC
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	63.0	65.0	65.0	66.0	66.0	66.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	11	85	13	13
Annual Indicator	18.3	19.9	19.9	19.9
Numerator	211	204	204	204
Denominator	1,152	1,024	1,024	1,024
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2015	2015

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	85	11	85	13	13
Annual Indicator	10.7	13.2	12.2	86	86
Numerator	104	110	79	7,734	7,734
Denominator	969	832	650	8,989	8,989
Data Source	WIC	WIC	WIC	MCH-JS	MCH-JS
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	14.0	14.0	15.0	16.0	16.0	16.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of infants ever breastfed

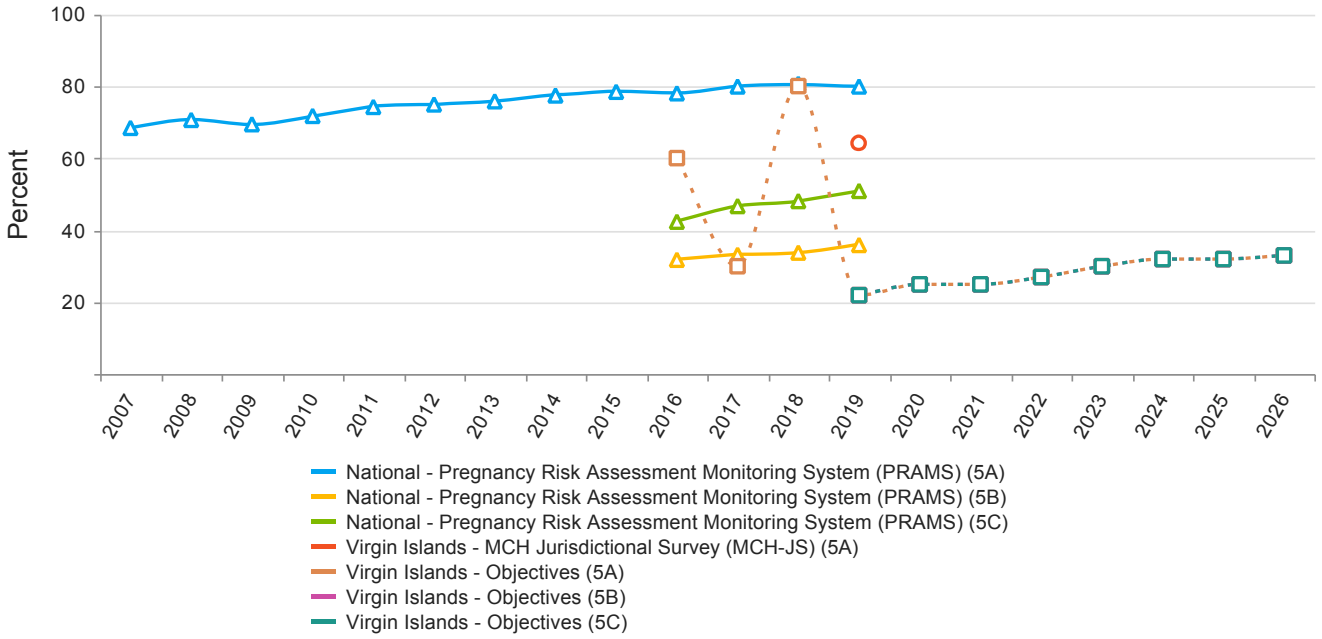
Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			62
Annual Indicator		85.9	44.5
Numerator		79	433
Denominator		92	974
Data Source		MIECHV and MCH-JS	Nurse Liaison Report and VI State Plan WIC
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	63.0	63.0	65.0	66.0	66.0	67.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	22	25
Annual Indicator	64.1	64.1
Numerator	576	576
Denominator	899	899
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	60	30	80	22	25
Annual Indicator	60	80	20.8	64.1	64.1
Numerator	30	40	5	576	576
Denominator	50	50	24	899	899
Data Source	MIECHV	MIECHV	MIECHV	MCH-JS	MCH-JS
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	27.0	30.0	32.0	32.0	33.0

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2017	2018	2019	2020
Annual Objective			22	25
Annual Indicator	80	20.8	64.1	64.1
Numerator	40	5	576	576
Denominator	50	24	899	899
Data Source	MIECHV	MIECHV	MCH-JC	MCH-JS
Data Source Year	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	27.0	30.0	32.0	32.0	33.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2017	2018	2019	2020
Annual Objective			22	25
Annual Indicator	64	20.8	73.7	34.8
Numerator	32	5	14	8
Denominator	50	24	19	23
Data Source	MIECHV	MIECHV	MIECHV	MIECHV
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	27.0	30.0	32.0	32.0	33.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Percent of families receiving safe sleep educational materials at District birthing hospitals.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			70
Annual Indicator		95.5	100
Numerator		1,064	974
Denominator		1,114	974
Data Source		Hospital Statistics	Hospital Liaison Nurse Report
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	78.0	80.0	85.0	85.0	100.0

State Outcome Measures

SOM 1 - Percentage of pregnant women who receive prenatal care beginning in the first trimester

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	85.5	
Numerator	1,674	
Denominator	1,958	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.5	90.0	91.0	92.0	93.0	93.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Perinatal/Infant Health - Entry 1	
Priority Need	
Increase the number of families educated on safe sleep practices	
NPM	
NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
Objectives	
Increase the number of families that receive educational information of counseling about safe sleep by 6% each year	
Strategies	
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 including FQHCs and Homevisiting Staff on safe sleep practices	
ESMs	**Status**
ESM 5.1 - Percent of families receiving safe sleep educational materials at District birthing hospitals.	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

State Action Plan Table (Virgin Islands) - Perinatal/Infant Health - Entry 2

Priority Need

Increase the number of women breastfeeding up to six months

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

Increase the number of pregnant women who receive breastfeeding at 6 months up to a year

Strategies

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

ESMs	Status
ESM 4.1 - Percent of infants ever breastfed	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Priority Need: Increase the number of women breastfeeding up to six months

NPM 2: Percentage of infants who are ever breastfed b) percentage of infants breastfed exclusively through six months.

Increasing the number of women breastfeeding remains a top priority for the Virgin Islands. VI MCH understands the importance of breastfeeding. Breast milk provides ideal nutrition for babies and help keep them healthy. Breastfed babies become healthier children with fewer instances of allergies, eczema, and asthma, childhood cancers and lower risk of type I and II diabetes. Breastfeeding burns extra calories, so you can lose weight faster. It releases the hormones oxytocin which helps your uterus to return to its pre pregnancy size and may reduce uterine bleeding after birth.

VI WIC continues to maintain a high breastfeeding rate where 70% of infants breastfed compared to a national rate of 32%. This is an increase from last year. WIC staff, including BFPC and breastfeeding counselors worked diligently during the pandemic to encourage moms to breastfeed through social media and phone contacts.VI operates a breastfeeding Peer Counselor Program. Likewise, there has been a 6% increase in women breastfeeding to 86% last year.

VI MCH continues to educate and encourage pregnant women about the benefits of breastfeeding. Although the breastfeeding rate in the territory is increasing every year, we find that it is necessary to continue to report on this NPM because of the many benefits. Most women enter pregnancy overweight, and this persist during and after pregnancy. Mother who breastfeeds recover from childbirth more quickly and easily. Breastfeeding burns extra calories, so you can lose weight faster. Studies has also shown that breastfeeding reduces the risk of breast and ovarian cancer.

Priority: Increase the number of families educate on safe sleep practices
NPM 5: Percent of infants placed to sleep on their backs B) Percent of infants placed on a separate approved space

To improve infant care practices and ultimately reduce sleep related infant deaths, hospitals in the territory provide mothers with safe sleep education prior to leaving the hospital after giving birth. This process is included in the teaching plan at both hospitals. Every family is shown a safe sleep video before they are discharged from the hospital.

Learning about safe sleep for babies is important for all caregivers. Simple caregiving techniques can play a critical role in keeping an infant safe during sleep. MCH continues to provide safe sleep education to pregnant mothers and mothers with newborn babies.

Breastfeeding

In the upcoming year, MCH will continue to inform all pregnant women and women with babies within the breastfeeding age about the benefits and management of breastfeeding. Research has shown that breastfeeding is recognized as the best source of nutrition for most infants. Making the decision to breastfeed is a personal matter. However, because of its relationship with the birth experience, breastfeeding should be supported throughout the entire maternity hospital stay, not postponed until the infant goes home.

It is extremely important for mothers to understand the benefits of breastfeeding. Many medical experts, including the American Academy of pediatrics (AAP) recommend breastfeeding exclusively for six months. After the introduction of other foods, it recommends continuing to breastfeed through the baby's first year of life. Breastmilk have nearly a perfect mix of vitamin, protein and fat, everything a baby needs to grow.

Additionally, MCH Division welcomes a new OBGYN that will be providing services to our prenatal population. In the interim, 16 new patients are registered for prenatal care. 8 of the 14 new clients began their prenatal care in their first trimester. In September the OB/GYN availability will increase to render full time services.

Safe Sleep

Promoting safe sleep practices is a public health priority. Sleep related deaths are one of the leading causes for infants between 1 month and 1 year of age. However, most sleep related deaths are a preventable cause of death in infants. Simple care giving techniques can play a critical role in keeping infants safe during sleep.

To improve infant care practices and ultimately reduce SIDS and other sleep related infant deaths, innovative strategies that educate caregivers about safe sleep need to be developed. The MCH Division will continue to educate parents on safe sleep practices at every well child visit for the first year of life. MCH will coordinate outreach activities to share educational material about safe sleep to pregnant mothers and mothers with babies within the breastfeeding age. The information will encourage families to ensure babies are always on their own sleep surface. Caregivers should understand that bed sharing is a risk factor for sleep related deaths, babies should be on their back for every sleep and the crib surface should be empty.

Child Health

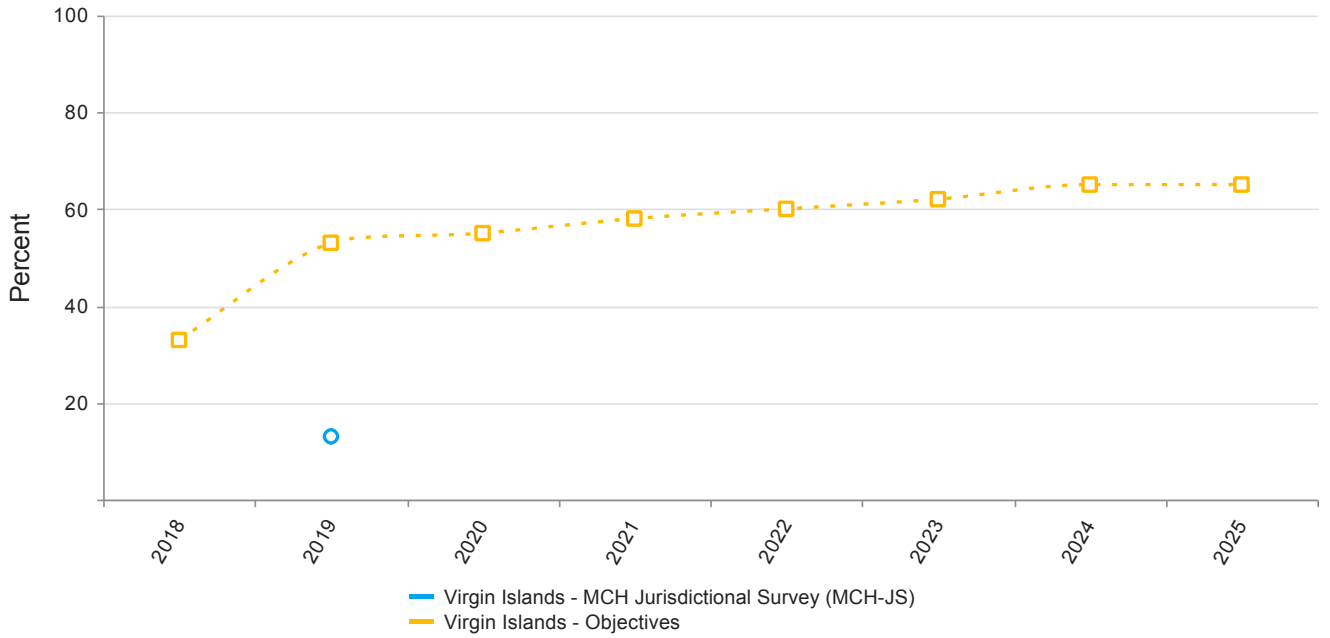
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	MCH-JS-2019	12.3 %	NPM 13.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	10.8 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	83.4 %	NPM 6 NPM 8.1 NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 6 NPM 8.1 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 0-2	Data Not Available or Not Reportable	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 10-17-2019	27.6 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	15.1 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	Data Not Available or Not Reportable	NPM 8.1

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Indicators and Annual Objectives



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	53	55
Annual Indicator	13.2	13.2
Numerator	450	450
Denominator	3,422	3,422
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			33	53	55
Annual Indicator	100	22.7	53.6	13.2	13.2
Numerator	30	85	374	450	450
Denominator	30	374	698	3,422	3,422
Data Source	MIECHV	MIECHV	MIECH and Title V Special Pediatrics	MCH-JS	MCH-JS
Data Source Year	2017	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	58.0	60.0	62.0	65.0	65.0	65.0

Evidence-Based or –Informed Strategy Measures

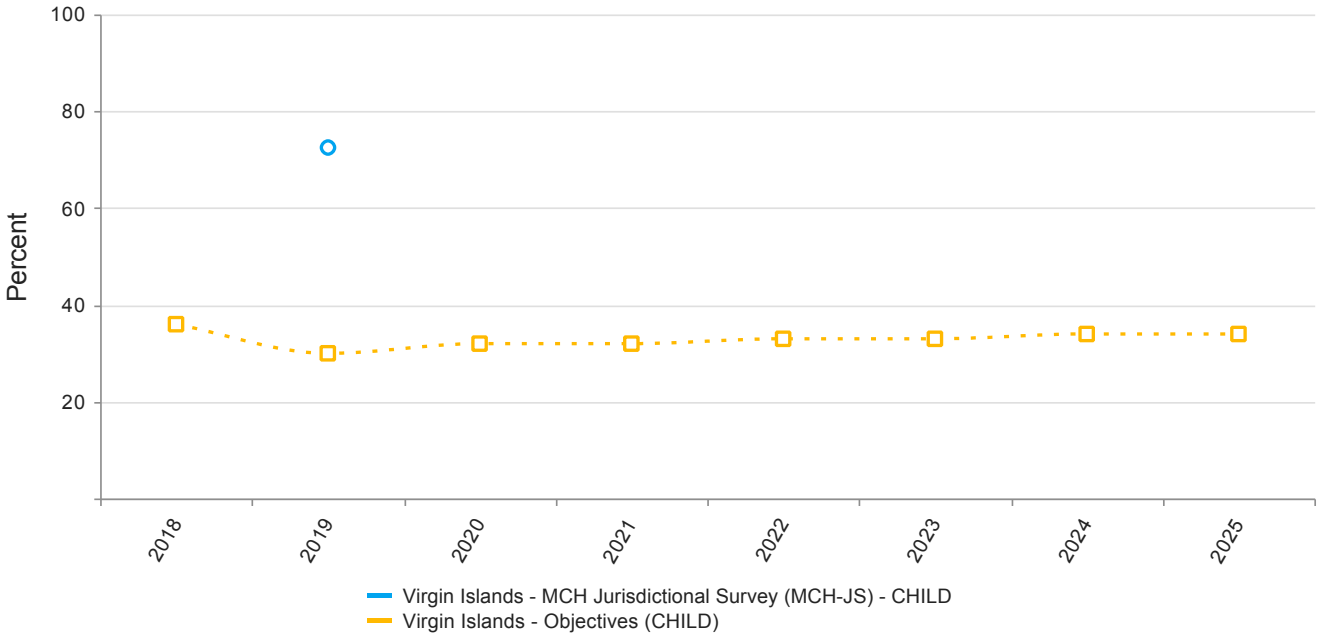
ESM 6.1 - Children receiving a developmental screening using a parent-completed screening tool.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			55
Annual Indicator		86.3	82.2
Numerator		164	217
Denominator		190	264
Data Source		Zero to Three and MIECHV	Zero to Three and MIECHV
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	58.0	60.0	62.0	65.0	65.0	75.0

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD		
	2019	**2020**
Annual Objective	30	32
Annual Indicator	72.5	72.5
Numerator	6,568	6,568
Denominator	9,054	9,054
Data Source	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			36	30	32
Annual Indicator	30.2	30.2	30.2	72.5	72.5
Numerator	2,484	2,484	2,484	6,568	6,568
Denominator	8,237	8,237	8,237	9,054	9,054
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	MCH-JS	MCH-JS
Data Source Year	2011_2012	2011_2012	2011_2012	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.0	33.0	33.0	34.0	34.0	35.0

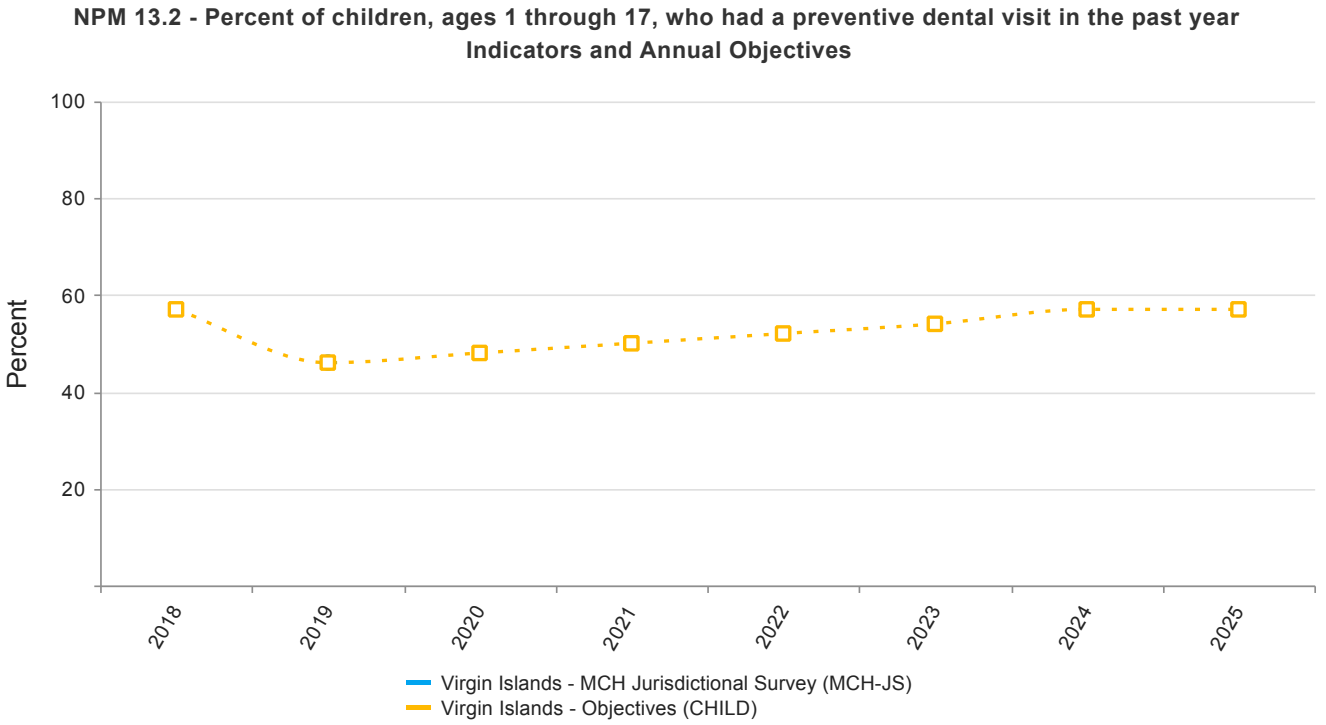
Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Physical activity counseling during the well-child visit within the MCH population.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		50	58	68	70
Annual Indicator	49.7	57.3	66.4	79.1	27.9
Numerator	1,265	1,787	2,671	8,595	628
Denominator	2,547	3,120	4,020	10,868	2,247
Data Source	FQHC Data	FQHC Data	FQHC and MCH Clinics	DOE	FQHCs
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	70.0	72.0	74.0	74.0	74.0



NPM 13.2 - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	46	48
Annual Indicator	46.0	46.0
Numerator	12,017	12,017
Denominator	26,127	26,127
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			57	46	48
Annual Indicator	37.8	37.8	45	46	46
Numerator	4,116	4,116	7,949	12,017	12,017
Denominator	10,888	10,888	17,650	26,127	26,127
Data Source	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS DATA	MCH-JS	MCH-JS
Data Source Year	2017	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	54.0	57.0	57.0	58.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percent of Children, ages 1-17, who have had Preventive Dental Health visit in the past year

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			46	48
Annual Indicator		8.8	8.9	21.1
Numerator		971	965	2,509
Denominator		11,000	10,868	11,899
Data Source		FQHCs Data	FQHCs Data and DOE	USVI FQHC UDS HS/EHS PIR
Data Source Year		2018	2019	2019 2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	54.0	57.0	48.0	48.0

State Outcome Measures

SOM 2 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.2	
Numerator	3,554	
Denominator	27,026	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2021	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.1	13.5	14.0	15.0	15.0	15.0

SOM 3 - Percent of children , ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	55.3	
Numerator	500	
Denominator	904	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2021	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.3	56.0	57.0	58.0	60.0	62.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Child Health - Entry 1	
Priority Need	
Decrease the number of children with BMI>85%	
NPM	
NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	
Objectives	
To promote regular physical activity in children ages 6-11	
To encourage healthy eating 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	
Strategies	
To collaborate with sports park and recreation and host out door sporting activities	
provide educational material to families about the importance of healthy eating	
Partner with the Department of Education to host in school sporting events	
ESMs	**Status**
ESM 8.1.1 - Physical activity counseling during the well-child visit within the MCH population.	Active
NOMs	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	

State Action Plan Table (Virgin Islands) - Child Health - Entry 2

Priority Need

Increase the percent of developmental screenings done in the territory

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

To increase the percentage of developmental screening done in the territory for children 9-35 months

Strategies

Utilize Homevisiting /MIECHV programs to provide Ages and Stages Developmental Screening tool with clients

Train medical social workers and childcare providers on developmental screening

ESMs	Status
ESM 6.1 - Children receiving a developmental screening using a parent-completed screening tool.	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Virgin Islands) - Child Health - Entry 3

Priority Need

Increase access to oral health care for the Maternal Child health population

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

To increase access to oral health care for the Maternal Child Health population

Strategies

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

ESMs	Status
ESM 13.2.1 - Percent of Children, ages 1-17, who have had Preventive Dental Health visit in the past year	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Virgin Islands) - Child Health - Entry 4

Priority Need

Increase the percent of developmental screenings done in the territory

SOM

SOM 2 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Objectives

To increase the percent of developmental screening for children with special health care needs between the ages of 0 through17

Strategies

To collaborate with Birth to Three to ensure Early Intervention is provided for those children with developmental delays

Priority Need: Decrease the number of children with BMI > 85%

NPM 8: Percent of children, ages 6 through 11 who are physically active at least 60 minutes per day

VI MCH continues to promote exercise and good diet to help curb obesity in children and their families. Regular physical activity can help children and adolescents improve cardiorespiratory fitness, build strong bones and muscles, control weigh and reduce the risk of developing health condition such as obesity. In September of 2020, the program launched a "Let's Get Active Campaign". Every Thursday, a fitness instructor engages families in a host of physical activities to help improve the health and reduce the risk of developing diseases such as obesity and type 2 diabetes in children. Weekly, over 1,000 families participate in the virtual soca aerobics class.

A healthy diet is important for good health and nutrition. To help families improve food choices and to encourage the integration of exercise into daily activities, VI MCH launched a nutrition education campaign. In support of National Nutrition Month, a nutrition jingle and video promoting healthy eating was created. MCH partnered with the Women & Infant Children (WIC) program and held the "Let's Talk Nutrition Talk Show". Each week, the hosts engaged three youth panelists in discussion about the importance of healthy eating and exercise. The panelist ranged from 3 to 18 years old. Over a course of 4 weeks 3,054 families engaged in the virtual live activity.

MCH held a virtual "Let's Cook VI Style Cooking Activity" during Nutrition Month. The focus was to encourage families and children within the VI community to find nutritious ways towards a healthier lifestyle. Children and parents received insight on this topic from a member of the WIC Program while enhancing their culinary skills with a local chef and his family. The Project LAUNCH team provided an opportunity for children to learn new skills and engage with family members despite the virtual circumstances. The activity encouraged children and their families to connect over meals and provided the opportunity to highlight moments for family strengthening while cooking a healthy, delicious meal.

Priority: Increase the percent of developmental screenings done in the territory

MCH continues to collaborate with the Birth to Three program to ensure developmental delays in children are recognized and treated early. When a developmental delay is not recognized early, children must wait to get the help they need. A development delay is when a child does not reach certain milestones at the same time as other children. Developmental screening provides a quick check of a child's development. It can be thought of as a snapshot of the child's motor, cognitive, language, and social-emotional skills. Screening will help determine if your child is meeting the appropriate milestones for their age. Doctors and nurses use developmental screening to tell if children are learning basic skills when they should, or if they might have problems.

During autism awareness month in April, VI MCH provided opportunities to increase the understanding and acceptance of individuals with autism by sharing educational information. The information was shared through ads aired on radio stations across the territory. As we continue to promote the well-being of children and their families it is our goal to see all children and families receive quality, holistic health care.

Child Health - Application Year

Decreasing the number of children with BMI > than 85 is important to VI MCH area will continue to be a focal are for the program. Obesity in children poses immediately and future health risk. Causes of obesity in children include unhealthy food choices, lack of exercise and family eating habits. Having obesity puts people at risk for many other serious chronic diseases and increases the risk of severe illness from Covid 19. Lifestyle and diet changes can help children to maintain a healthy weight.

Covid-19 restrictions such as closure of school and the cancellation of youth and sports activities has made it difficult for people to manage many aspects of their lives, especially physical activity. Many children have become more inactive because of changes to their routine and the inability to participate in sports and be with their friends. MCH will continue to host virtual soca aerobics classes on Thursday. Families can stay safe as we continue to help stop the spread of Covid-19 while engaging in exercise activities.

MCH will continue to implement strategies to address obesity in children. The program will continue to encourage collaborations with the WIC program to provide healthy eating habits that will promote a healthy lifestyle among the MCH population. Partnership with the Chronic Disease Division is inevitable. Obesity is a common, serious, and costly chronic disease. MCH will explore partnership with the Department of Education to sponsor sports tournaments to encourage fun physical exercise. A collaboration with the Medical Assistance Program (MAP) is in the works. Everyone has a role to play in turning the tide against obesity and its disproportionate impact on the vulnerable population.

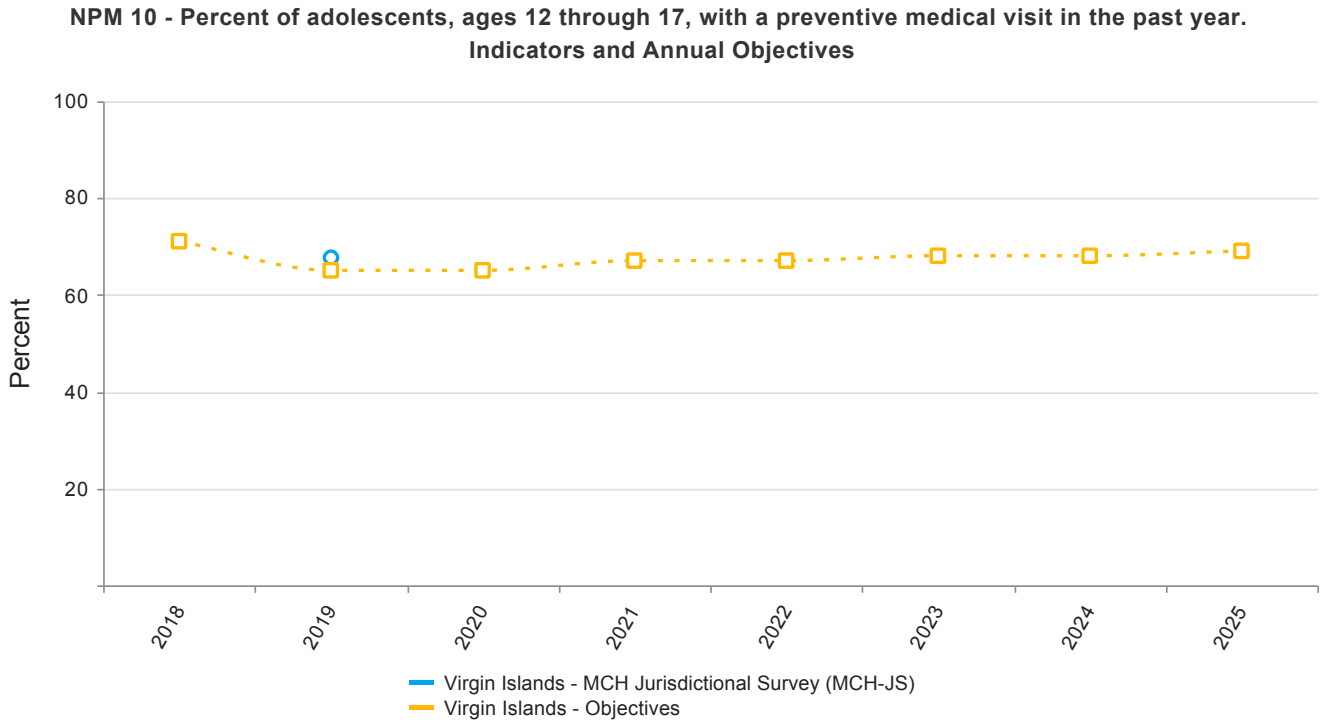
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	MCH-JS-2019	12.3 %	NPM 13.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	Data Not Available or Not Reportable	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	Data Not Available or Not Reportable	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	Data Not Available or Not Reportable	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	10.8 %	NPM 10 NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 10 NPM 13.2
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	MCH-JS-2019	55.2 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	83.4 %	NPM 10 NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 10 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 0-2	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 10-17-2019	27.6 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	15.1 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	Data Not Available or Not Reportable	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	38.2 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	48.8 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	79.2 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	75.0 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	25.4	NPM 10

National Performance Measures



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	65	65
Annual Indicator	67.7	67.7
Numerator	6,085	6,085
Denominator	8,984	8,984
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			71	65	65
Annual Indicator	65.2	65.2	65.2	67.7	67.7
Numerator	6,103	6,103	6,103	6,085	6,085
Denominator	9,355	9,355	9,355	8,984	8,984
Data Source	NSCH	NSCH	NSCH	MCH-JS	MCH-JS
Data Source Year	2011_2012	2011_2012	2011_2012	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	67.0	67.0	68.0	68.0	69.0	70.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			5
Annual Indicator		63	1.6
Numerator		6,848	178
Denominator		10,868	10,907
Data Source		DOE	MCH EDHI and VIDE school enrollment
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	15.0	20.0	25.0	65.0	65.0

State Performance Measures

SPM 3 - Increase access to comprehensive primary and preventive health care for adolescents and pre-adolescents ages 10-19 years.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		22	25	25	25
Annual Indicator	22.1	21.1	17.7	31.4	19.9
Numerator	2,611	2,492	2,086	3,412	2,185
Denominator	11,803	11,803	11,803	10,868	10,981
Data Source	MCH and FQHCs	MCH and FQHCs/Community Survey	FQHCs/Community Survey	FQHC, MCH and DOH	MCH FQHCs
Data Source Year	2016	2017	2018/2013	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.0	28.0	30.0	31.0	31.0	33.0

State Outcome Measures

SOM 2 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.2	
Numerator	3,554	
Denominator	27,026	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2021	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.1	13.5	14.0	15.0	15.0	15.0

SOM 3 - Percent of children , ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	55.3	
Numerator	500	
Denominator	904	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2021	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.3	56.0	57.0	58.0	60.0	62.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Adolescent Health - Entry 1	
Priority Need	
Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents	
NPM	
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	
Objectives	
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	
Strategies	
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	
ESMs	**Status**
ESM 10.1 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services.	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Virgin Islands) - Adolescent Health - Entry 2

SPM

SPM 3 - Increase access to comprehensive primary and preventive health care for adolescents and pre-adolescents ages 10-19 years.

Objectives

Increase access to comprehensive primary and preventative health care services for adolescents 10 to 17

Strategies

Develop a comprehensive Adolescent plan and include all stakeholders, such as DOE, DHS, DOH Divisions that serve the population, community partners etc.

State Action Plan Table (Virgin Islands) - Adolescent Health - Entry 3

SOM

SOM 3 - Percent of children , ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Objectives

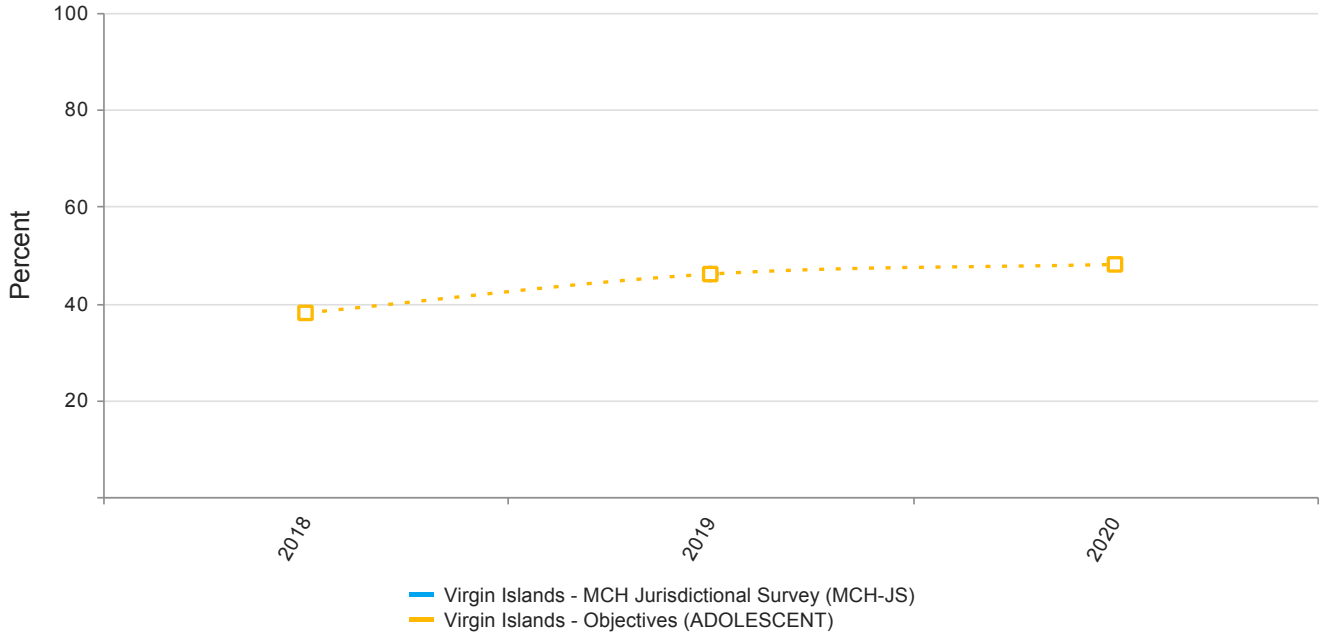
Increase the number of children between the ages of 3 to 17 who are screened for mental/behavioral health

Strategies

Partner with VI Project Launch and the Division of mental health to provide mental health screenings

2016-2020: National Performance Measures

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Indicators and Annual Objectives



2016-2020: NPM 13.2 - Adolescent Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	46	48
Annual Indicator	46.0	46.0
Numerator	12,017	12,017
Denominator	26,127	26,127
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			38	46	48
Annual Indicator	37.8	37.8	45	76.9	21.1
Numerator	4,116	4,116	7,949	8,357	2,509
Denominator	10,888	10,888	17,650	10,868	11,899
Data Source	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS Data, MCH and DOE	USVI FQHC UDS
Data Source Year	2017	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 13.2.2 - Increase access to dental health services through inter-agency partnerships and supportive services such as provider training and resources.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			2	2	2
Annual Indicator	0	1	0	1	1
Numerator					
Denominator					
Data Source	Title V Program	Title V Program	Title V Program	Title V Program	Title V Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Adolescent Health - Annual Report

Adolescent Health has always been a priority area for VI MCH. The 2020 Needs Assessment further identifies the importance of serving adolescents' wholistic health. Therefore, while obesity and other health concerns will continue to be important to our mission, the overall goal is to intentionally focus on the physical, social, emotional cognitive and intellectual health and well being of adolescents.

Adolescence (10-19 years) is a unique and influential time. To promote the psychological well-being and protect adolescents from adverse experiences and risk factors that may affect their potential to thrive, VI MCH engaged in several activities geared toward educating and engaging youth in healthy lifestyles. The Division hosted a Virtual Live "Let's Talk Youth Mental Health" talk show. Representatives from MCH & the Behavioral Health Divisions engaged the adolescent population ages 10-18 in discussion and conversation surrounding the mental health and well-being of our younger population. Over 1500 families viewed the event. Viewers had many positive responses about the show. One viewer said, "Very Smart Young Ladies, wishing then all the best". Another viewer wrote" I'm impressed with the young ladies, very important topic". The Talk show can be viewed on https://fb.watch/7EHZKx2lKm/.

Due to the Covid 19 pandemic, children are home all day and schools, and community centers are closed. Sports league and extracurricular activities such as dance and karate classes have been suspended. To assist families in keeping children active and addressing obesity in children during the Covid-19 pandemic, VI MCH hosts a virtual live weekly soca aerobics exercise class. Families can burn some calories while having fun with the MCH Division. This activity also allows families the opportunity to spend quality time together while keeping healthy. The aerobics class can be viewed on https://fb.watch/7HPs6Ulgue/

Multiple physical, emotional, and social changes, including exposure to poverty, abuse, or violence, can make adolescents vulnerable to mental health problems. It is very important to equip educators with methods for reaching out to students who may be developing mental health problems while deepening their understanding of why early intervention matters. MCH collaborated with the Department of education and hosted a Behavioral Health Basics training for school counselors and nurses. The training was geared towards promoting the well-being of children & adolescents within our school by increasing staff awareness and understanding of concepts related to behavioral health, to include mental health concerns, suicide risk & prevention, school bullying prevention and utilization of community resources for professional support. Greater Changes provided insights on behavioral health care services for children and families, focusing on Bullying and Abuse Recognition and Prevention.

Covid-19 delayed plans to create an adolescent committee. However, plans are still on the way for 2022. Adolescence is a critical transitional period and VI MCH acknowledges that creating an adolescent committee will aid in addressing emerging issues of adolescents. Harmonizing programs that cater to adolescents is critical to ensure each program is working together for the betterment of adolescents in the territory. Promoting psychological well-being and protecting adolescents from adverse experiences and risk factors that may impact their potential to thrive are critical for their well-being during adolescence and for their physical and mental health in adulthood.

Adolescent Health - Application Year

For the upcoming year VI MCH will focus on the holistic health of adolescents. Health care providers play an important role in fostering healthy behaviors among adolescents. While most adolescents at this stage of life are many of them have difficulty gaining access to necessary services while other engage in risky behavior that can jeopardize their health. Providing practical and natural ways to help teens stay physically and mentally fit is critical. Teen flourish from a wholistic approach to care.

Objectives

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
Percent of children, ages 3 through 17 with a mental health/behavioral condition who receive treatment or counseling

Strategies

Develop a State Adolescent Health Care Program 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 the adolescent population

Evidenced Based/Informed Strategy Measures

There are no specific state-wide public health programs dedicated to the health of adolescents. Title V continues to seek ways to improve engagement and advocacy among the adolescent population by developing a State Adolescent Program.

The goals of the State Adolescent Health Program would be to:

- Try to understand the issues that concern adolescents in the Virgin Islands
- Provide information to families and people working with adolescents
- Take a leadership role when planning and developing policies
- Link teenagers and their families to health services
- Promote new knowledge and competence in adolescent health
- Monitor effects to make health services easy to access effective and high quality support
- Support research that advances adolescent health

The Adolescent Health Program's target population is:

- Adolescents and young people between 10 and 17
- Teachers and parents of adolescents and young people
- Health care Providers of adolescent and young adults

MCH plans to partner with the Division of Behavioral Health, the FQHCs, Family Planning, Division of Communicable Diseases, Division of Chronic Disease and other community partners to support the needs of the adolescent population.

Children with Special Health Care Needs

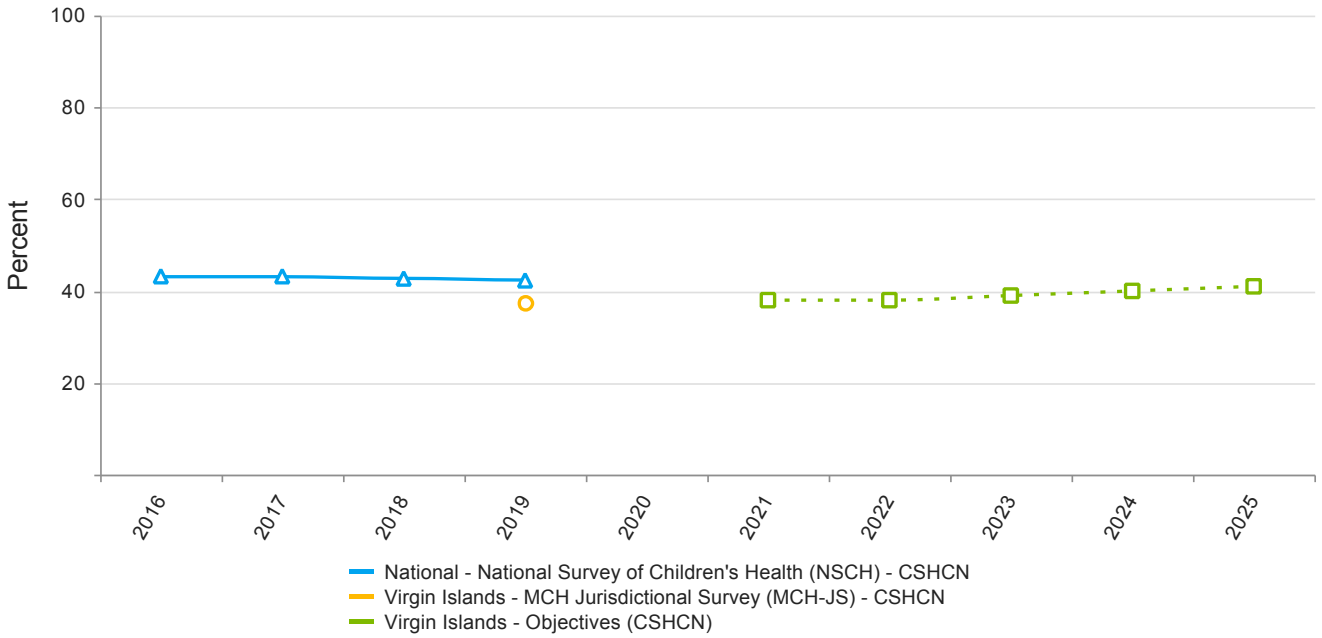
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	10.8 %	NPM 11 NPM 12
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	MCH-JS-2019	55.2 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	83.4 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	MCH-JS-2019	10.0 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH	Data Not Available or Not Reportable	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	37.4	37.4
Numerator	1,329	1,329
Denominator	3,554	3,554
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	37.4	37.4
Numerator	1,329	1,329
Denominator	3,554	3,554
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	38.0	38.0	39.0	40.0	41.0	41.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	37.4	42.7
Numerator	1,329	1,110
Denominator	3,554	2,599
Data Source	VI	MCH Clinic Data and MCH-JS
Data Source Year	VI	2019 2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	38.0	38.0	40.0	41.0	42.0	44.0

State Performance Measures

SPM 2 - The percent of CSHCN clients who access family support services.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		80	80	74	78
Annual Indicator	78.2	79.2	71.1	32.4	32.4
Numerator	1,167	993	849	477	477
Denominator	1,493	1,254	1,194	1,471	1,471
Data Source	MCH Clinic and Allied Health Services	MCH Clinic and Allied Health	MCH Clinic, Allied Health and Medicaid	MCH and Zero to Three	MCH and Zero to three
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Provisional	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	81.0	82.0	83.0	83.0	83.0

State Outcome Measures

SOM 2 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.2	
Numerator	3,554	
Denominator	27,026	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2021	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.1	13.5	14.0	15.0	15.0	15.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Increase percentage of families that participate in transition planning	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
Increase the number of families for CSHCN that participate in the transition process by 2%	
Strategies	
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	
ESMs	**Status**
ESM 11.1 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

State Action Plan Table (Virgin Islands) - Children with Special Health Care Needs - Entry 2

Priority Need

Increase the percent of developmental screenings done in the territory

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

Increase the percentage of clients who access family support services

Strategies

Partner with infant and Toddlers to ensure Early Intervention is provided for those with developmental delays

ESMs	Status
ESM 11.1 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Virgin Islands) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase percentage of families that participate in transition planning

SPM

SPM 2 - The percent of CSHCN clients who access family support services.

Objectives

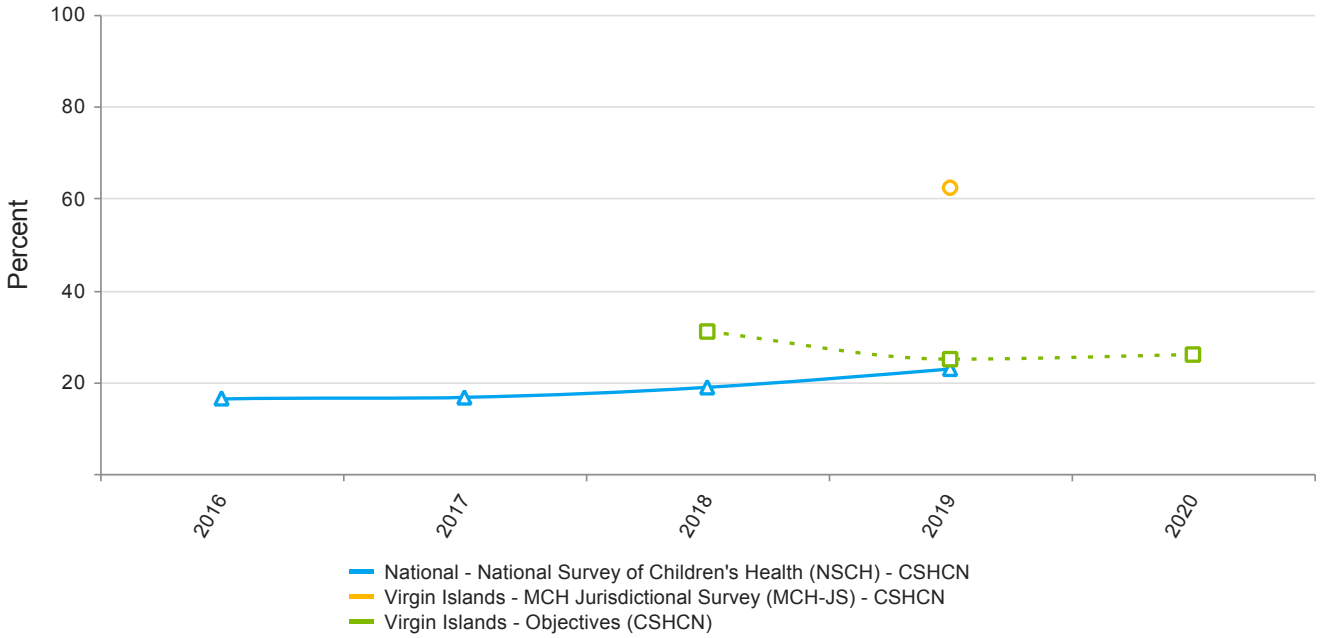
Increase the number of clients who access family support services

Strategies

Collaborate with Birth to 3 and other Early Intervention Programs to ensure Early Intervention is provided for those with developmental delays

2016-2020: National Performance Measures

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



2016-2020: NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective	25	26
Annual Indicator	62.3	62.3
Numerator	852	852
Denominator	1,366	1,366
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			31	25	26
Annual Indicator	24.9	24.9	24.9	62.4	
Numerator	212	212	212	852	
Denominator	850	850	850	1,366	
Data Source	NS-CSHCN	NSCH	NSCH	MCH-JS	
Data Source Year	2009_2010	2009_2010	2009_2010	2019	
Provisional or Final ?	Final	Final	Final	Final	

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 12.1 - Use of evidenced-based health care transition tools in public health and FQHC facilities.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1	1	1	1
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	MCH Program	MCH Program	MCH Program	MCH program	MCH and CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final	Provisional

The MCH/CSHCN Program continues to be committed to provide comprehensive, wholistic services to the territory pediatric population including services to children with special health care needs. The MCH/CSHCN program remains focused on providing all the specialty services for the pediatric population. Through direct services we provide the pediatric Neurology Specialty (on contract) and Audiology Services. The MCH pediatricians have also provided care and close monitoring for children with sickle cell disease and diabetes. Indirectly, through a referral system all other pediatric specialties are provided for from the San Jorge children's Hospital and the Jack Nicholas Children's Hospital in Florida. The Medical Assistance program ensures that the payments are done for all children who qualify. The MCH program supports children with financial hardship to receive the specialty services they require via the utilization of Title V funding.

The MCH/CSHCN Pediatricians and the Nursing staff remain relentless in ensuring all genetic counseling and teachings are done for all children with positive metabolic screens. Via the utilization of home visiting any family who is determined as hard to reach will be visited to ensure that the notification process is completed.

In the community, MCH/CSHCN continues to provide services via the utilization of the Public Health Mobile van/clinic. MCH/CSHCN continues to support the head start program for the mandatory annual physical, eye screening and audiology screening.

The Early intervention program (Birth-Three), is also an integral part of our delivery care system, providing services to our Special Health Care Needs population. A very effective referral system has been in effect for many years between the HI Risk Clinic and the 0-3 program. The referral system was instituted to ensure that the children referred for services remains under the direct care of their primary health care providers (Pediatricians and Nurses) from a collaborative multidisciplinary approach. All Children exhibiting early signs and symptoms of developmental delays or existing biological health issues are referred and followed closely by the Hi Risk Clinic. The birth to three programs is housed in the MCH clinic on St. Thomas and St. Croix. All pediatricians in the territory are encouraged to utilize the service.

The MCH High Risk Clinics Held every Tuesday continues to monitor all children born to Hi Risk mothers, premature infants, children born to teen moms and children noted to have any form of environmental or biological challenges. The medical social worker is available on site to expedite the necessary inter island or off island referrals as needed. A sample of referrals generated by this clinic for children with special health care needs includes physical therapy, speech therapy, audiology services, occupational services, developmental specialist services and much more. The Hi Risk Clinic transitions all children with Special Health care Needs to the Special Pediatric clinic (Special Peds). This clinic services Children with Special Health care needs ages 13 months -21 yrs. old.

The Special Peds Clinic is held every Monday, with a special exception for the Hematology clinic, which is held the 1st Friday of every month for children with Sickle Cell disease. An MCH Pediatrician is the lead person in this clinic. The focus of the Special Pediatric Clinic is to provide services for all children with special health care need in a small, personalized setting. This clinic encourages support groups such as the diabetic support group. All children born to Zika positive mothers are now part of the Special pediatric population and will be easy to monitor and identify until age 21. Children with chronic upper airway conditions such as asthma are also part of the group.

Children with Special Health Care Needs - Application Year

Application

This application year the focus is still on improving the system of care for CSHCN in the territory to maximize outcomes for women pregnant women and children. The jurisdiction survey of 2019 showed that out of 207 families surveyed, 13% indicated having children with special health care needs. In response to a query regarding receipt of care in a "well-functioning system", responses reflected that only 11% of CSHCN were receiving care in a "well-functioning system" (n=38). Further, respondents identified 63% of children as ***not*** having a medical home. With respect to access to needed health care, respondents indicated that, in the past year, 20% of CSHCNs did not receive health care needed (n=38). For adolescents (ages 12-17) with special health care needs, respondents reported that 62% have received the necessary services to make the necessary transitions to adult health care (n=12).

Objectives

Increase the number of families for Children with Special Healthcare Needs (CSHN) that participate in the transition process by 3%
Increase the number of clients who access family support services

Strategies

Train employees in the GOT Transition Model to promote family involvement in a structure manner
Utilize GOT Transition model to promote family involvement
Collaborate with other DOH Division and other Agencies in the transition process
Collaborate with Birth to 3 and Other Early Intervention Programs to ensure Early Intervention is provided for children with special health care needs

Evidenced Based/Informed Strategy Measures

In order to address some of the needs of our clients with Special Health Care Needs, the MCH program proposes to create Specialty Clinics/Training Education for clients and their families. The St. Thomas MCH program has already begun these types of sessions primarily focusing on the patients with Diabetes. It is the intention of the MCH program to expand these sessions to include several of the other illnesses that require more education and management. –
These sessions are for the children with any of the following health challenges and their parents for them to get a better understanding of the disease process and its management. The **goal** is to educate our families and empower them to take control of their health, such that they live their best life.

1. Asthma Clinic
2. Seizure Clinic
3. Sickle Cell/ Hemoglobinopathy Clinic
4. Obesity/Healthy Weight Clinic -4 weeks using the WE CAN program

With the advent of COVID-19, these sessions can be conducted via Zoom to engage all the clients and still maintain safe protocols. This will also allow more participation of families since it will not require all the challenges of coming in to the clinic.

The Obesity/Healthy Weight clinic is a much-needed program given the numbers of obese VI children. The evidence is overwhelming that childhood obesity threatens the health and wellbeing of children globally, nationally, and locally. According to the Centers for Disease Control and Prevention (CDC), 1 in 5 (~ 13.7 million) children and adolescents in the United States are affected by childhood obesity. According to the VI DOH website, "the USVI 2017 Youth Risk Behavior Survey (YRBS) found that 37.2% of U.S. Virgin Islands' high school students were overweight or obese, which aligns with national trends. Furthermore, national data shows that Blacks and Hispanics have higher obesity rates than other racial and ethnic groups making the USVI's population more susceptible to higher rates."

It is a known fact that physical inactivity and poor diet are major contributing factors to childhood obesity. The 2017 YRBS data classified 21.2% of high school students as obese. A significant number of students reported that they did not consume fruits or vegetables regularly, nor did they engage in daily physical activity- all factors that contribute to the high prevalence of childhood and adolescent obesity in the territory. Lifestyle changes and attitudes must change to be successful in combating the problem of obesity, and this requires a family approach.

The VI DOH is sponsoring several activities during the month of September, which is National Childhood Obesity Awareness Month. Their goal is to "highlight the prevalence of childhood obesity; address its impact; and provide resources and support for families in assessing, preventing, and treating childhood obesity." Some of the activities include:

1. Let's Get Active Campaign – every Thursday Nigh 6:00PM-7:00PM
2. Virtual Healthy Classes for families
3. Obesity messages on Facebook and Twitter, radio and TV

The MCH program will support these efforts by encouraging the patients and families that are facing the challenges of childhood obesity to participate in these events.

Cross-Cutting/Systems Building

State Performance Measures

SPM 4 - Increase access to oral health care services for the child and adolescent MCH populations.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			30	33
Annual Indicator		8.8	8.9	7.2
Numerator		971	965	838
Denominator		11,000	10,868	11,589
Data Source		FQHCs Data	FQHCs Data	FQHC Data VIDE School HS EHS Enrollment
Data Source Year		2018	2019	2019 2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	34.0	36.0	36.0	40.0	40.0	40.0

State Outcome Measures

SOM 4 - Percentage of Children, ages 1 through 17, who have decayed teeth or cavities in the past year

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	12.3	
Numerator	3,214	
Denominator	26,127	
Data Source	National Survey of Childrens Health	
Data Source Year	2019	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	11.0	10.0	9.5	8.0	7.5	7.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Increase access to oral health care for the Maternal Child health population
SPM
SPM 4 - Increase access to oral health care services for the child and adolescent MCH populations.
Objectives
To establish a systematic methodology to assess the oral 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)."
Strategies
Develop Oral Health Steering Committee
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

State Action Plan Table (Virgin Islands) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Increase access to oral health care for the Maternal Child health population

SOM

SOM 4 - Percentage of Children, ages 1 through 17, who have decayed teeth or cavities in the past year

Objectives

Increase the number of children who receive a dental check-up at their annual check-up

Strategies

Train Providers to apply Vanish to clients during their annual checkup

Create PSA and social media ads to promote oral health education

Oral health impact multiple MCH populations and have an influence throughout the life course. There is a great need to increase oral health outcome in the territory. People with less access to oral health services are at a greater risk for oral health issues. Oral health is often neglected due to numerous barriers including lack of access, oral health education and insurance. Helping children develop healthy habits to care for their teeth while they are young is important. These habits can stage for good health care throughout their whole life. They can avoid many of the problems that result from poor oral health, including gum disease, cavities, and tooth decay.

To provide education to the MCH population about the importance of good oral health, MCH teamed up with the American Dental Association (ADA) and launched and oral health campaign during National Oral Health Month. The program developed a brush and floss oral health jingle and video that encouraged children to brush and floss twice a day to keep the cavities away. The jingle was played on radio stations across the territory. The video was aired on social media platforms such as Facebook, Instagram, and YouTube.

MCH collaborated with the American Dental Association and conducted a Brush and Floss community outreach on all four islands. Bags filled with toothbrush, toothpaste, mouth wash, a t-shirt that encourages children to brush and floss twice a day to keep the cavities away, and school supplies were distributed to over 500 children. The face of the Brush and Floss Oral Health campaign was displayed on billboards across the territory. The campaign was a huge success.

Implementation of oral health in the MCH clinics is on the way. MCH clinical staff will be trained to apply fluoride varnish to clients. Once the training occurs, application of fluoride varnish will be included as part of the annual well child visit. MCH is in the process of organizing a meeting with the chief dental officer at the Frederiksted Health Center (FHC) - and the St. Thomas East End Medical Center (STEEMCC)to discuss collaboration on increasing the number of young children who get sealant to prevent caries, as well as increasing the number of children that receive oral health care in the territory.

As we continue to work towards implementation of oral health services in the program, MCH will continue to conduct oral health outreaches to continue to provide education to the MCH population.

Cross-Cutting/Systems Building - Application Year

Improving the domain Cross Cutting /Systems Building is pertinent to the State Priority, increase access to oral health care for the Maternal Child population and the state outcome measure, increase access to oral health services for the child and adolescent MCH population. Practicing good dental health is important to maintain a healthy mouth, teeth and gum. It will also help your appearance and quality of life. However, there are some factors that influence access to dental care.

In the USVI, access to healthcare needs and services are addressed through Medicaid, Medicare, personal finances (uninsured) or third-party healthcare insurance. The 2015 VICS reported that 22% of the population did not have health insurance coverage. In 2016, approximately 55% of children younger than 9 years old were receiving medical services through Medicaid and 61% of children in the Territory between the ages of 10 and 19 years old were uninsured (Health Resources and Services Administration UDS Data Center, 2016).

Objectives

To establish a systematic methodology to assess the oral health needs of the child/adolescent population in the US Virgin Islands

Strategies

Develop an Oral Health Steering Committee
Provide State Approved Fluoride Vanish Training for Pediatricians, Nurses and other clinical staff
Include application of fluoride vanish as part of the wellness visit

Evidenced Based/Informed Strategy Measures

Title V plans to Develop an Oral Health Steering Committee whose goal will be create a coordinated system of oral health care in the Virgin Islands. The system will include a stakeholder-driven process that will:

- Develop needs assessment-to determine VI oral health needs
- Evaluate findings of Needs Assessment
- Develop a plan of action plan
- Execute plan

Oral Health remains a cross cutting area of concern for the VI. Oral health is the key component of overall health and well-being at all stages of life. However, many families cannot afford the cost of much needed oral health care. Title V plans to integrate the application of fluoride vanish into the well child visit. Application of fluoride vanish will aid in preventing dental carie. Fluoride vanish is billable by Medicaid allowing assess to oral care to vulnerable populations such as the underinsure and uninsured population.

III.F. Public Input

The Virgin Islands Department of Health invites public review and input relative to planning for and writing the Title V Five-Year Block Grant Application and Program Plan for the Maternal Child Health & Children with Special Health Care Needs (MCH & CSHCN) Program.

Notification on the availability of the block grant application and an invitation to the community to provide comments are made via several modalities: The Department of Health website, local newspapers, social media, and public access television stations. Copies of the grant application are also available upon request to agencies and partners. Response forms accompany each copy with options to accept the application as written or accept with changes and / or additions.

The MCH Program also continues to receive public input throughout the year via Advisory Committee meetings and through discussions with various partners at Stakeholders meetings.

III.G. Technical Assistance

The Virgin Islands Title V MCH Block grant received technical assistance from The National Maternal and Child Center for Oral Health Systems Integration and Improvement. The TA allowed VI MCH to establish a set of national MCH oral health quality indicators for monitoring oral health care delivery within existing systems of care; and translates evidence to practice by developing and disseminating action-oriented educational resources for systems integration and workforce development.

The Title V program aims to establish a systematic methodology to assess the oral health needs of the Child/adolescent population in the US Virgin Islands. VI MCH plans to utilize the Association of State and Territorial Dental Directors screening survey (BSS) to obtain data for an oral health surveillance system.

Key recommendations offered by the COHSII Technical Assistance:

- Insufficient access to oral health care, including preventive care, affects children's health, educational success, and ability to prosper.
- Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a positive attitude about oral health professionals and dental visits.
- Pregnant women who receive oral health care are more likely to take their child to get oral health care.

State MCH programs have long recognized the importance of improving the availability and quality of care to improve oral health for pregnant women, children, and adolescents.

The technical training assist the VI to:

- Develop an Oral Health Steering Committee
- Provide State Approved Fluoride Vanish Training for Pediatricians, Nurse and other clinical staff
- Include application of Fluoride Vanish as part of the wellness visit

Oral health care remains the greatest unmet health need for children in the United States. VI MCH will continue to engage in the COHSII and other technical trainings. Other TA's will be requested to ensure that the children of the Virgin Islands have access to oral care.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MCH and CSHCN 1995 Statement of Agreement 1.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Revised MCH_ORGCHART-20.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Virgin Islands

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,493,758	
A. Preventive and Primary Care for Children	$ 448,128	(30%)
B. Children with Special Health Care Needs	$ 448,128	(30%)
C. Title V Administrative Costs	$ 149,375	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,045,631	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,169,459	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,169,459	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,169,459		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 2,663,217	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 5,715,008	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 8,378,225	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,000,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Zika Maternal and Child Health Services Program	$ 1,074,008
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > VI Project Launch	$ 550,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Zika Health Care Services Program	$ 2,791,000

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,488,491		$ 1,493,758	
A. Preventive and Primary Care for Children	$ 446,548	(30%)	$ 450,423	(30.1%)
B. Children with Special Health Care Needs	$ 446,548	(30%)	$ 476,234	(31.8%)
C. Title V Administrative Costs	$ 147,981	(9.9%)	$ 149,375	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,041,077		$ 1,076,032	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0		$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,169,459		$ 1,559,491	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,169,459		$ 1,559,491	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,169,459				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 2,657,950		$ 3,053,249	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 2,924,008		$ 2,564,558	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 5,581,958		$ 5,617,807	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Zika Maternal and Child Health Services Program	$ 1,074,008	$ 1,074,008
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000	$ 37,550
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 250,000
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 550,000	$ 450,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,000,000	$ 753,000

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: VI MCH was allotted and spent in access of the maintenance of effort amount budget	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Virgin Islands

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 220,000	$ 150,234
2. Infants < 1 year	$ 149,376	$ 174,350
3. Children 1 through 21 Years	$ 448,128	$ 450,423
4. CSHCN	$ 448,128	$ 476,234
5. All Others	$ 78,751	$ 93,142
Federal Total of Individuals Served	$ 1,344,383	$ 1,344,383

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 233,891	$ 416,235
2. Infants < 1 year	$ 184,888	$ 167,715
3. Children 1 through 21 Years	$ 315,000	$ 325,225
4. CSHCN	$ 345,680	$ 434,134
5. All Others	$ 90,000	$ 216,182
Non-Federal Total of Individuals Served	$ 1,169,459	$ 1,559,491
Federal State MCH Block Grant Partnership Total	$ 2,513,842	$ 2,903,874

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Virgin Islands

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 1,265,632	$ 1,307,976
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 369,376	$ 338,802
B. Preventive and Primary Care Services for Children	$ 448,128	$ 492,940
C. Services for CSHCN	$ 448,128	$ 476,234
2. Enabling Services	$ 60,000	$ 100,950
3. Public Health Services and Systems	$ 168,126	$ 84,832
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 20,000
Physician/Office Services		$ 943,266
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 57,610
Dental Care (Does Not Include Orthodontic Services)		$ 20,000
Durable Medical Equipment and Supplies		$ 200,000
Laboratory Services		$ 67,100
Direct Services Line 4 Expended Total		$ 1,307,976
Federal Total	$ 1,493,758	$ 1,493,758

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 845,801	$ 1,343,309
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 185,121	$ 583,950
B. Preventive and Primary Care Services for Children	$ 315,000	$ 325,225
C. Services for CSHCN	$ 345,680	$ 434,134
2. Enabling Services	$ 200,010	$ 100,000
3. Public Health Services and Systems	$ 123,648	$ 116,182
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 90,000
Physician/Office Services		$ 658,818
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 54,230
Dental Care (Does Not Include Orthodontic Services)		$ 10,000
Durable Medical Equipment and Supplies		$ 350,000
Laboratory Services		$ 180,261
Direct Services Line 4 Expended Total		$ 1,343,309
Non-Federal Total	$ 1,169,459	$ 1,559,491

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Virgin Islands

Total Births by Occurrence: 974 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	973 (99.9%)	78	26	26 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase Synthase Deficiency	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia
S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency
Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy		

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Universal Hearing Screening	867	26	0	0
BWT	472	39	4	4
HIV	472	0	0	0
GBS	472	111	111	111
Substance Abuse	472	0	0	0
Alcohol Use	472	0	0	0

4. Long-Term Follow-Up

Zika Specialty Clinic:
EDHI:
Nuro:
Sickle Cell:
Speech:
Infant & Toddlers:

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Virgin Islands

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	681	21.0	0.0	29.0	0.0	50.0
2. Infants < 1 Year of Age	854	17.0	0.0	22.0	0.0	61.0
3. Children 1 through 21 Years of Age	10,677	46.0	0.0	12.0	15.0	27.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	154	0.0	0.0	0.0	0.0	100.0
4. Others	0					
Total	12,212					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	1,310	Yes	1,310	52.0	681	681
2. Infants < 1 Year of Age	1,314	Yes	1,314	65.0	854	854
3. Children 1 through 21 Years of Age	28,098	Yes	28,098	38.0	10,677	10,677
3a. Children with Special Health Care Needs 0 through 21 years of age^	3,853	Yes	3,853	4.0	154	154
4. Others	77,257	Yes	77,257	0.0	0	0

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Reference data were used to complete this element of Form 5.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Reference data were used to complete this element of Form 5.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Reference data were used to complete this element of Form 5.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Reference data were used to complete this element of Form 5.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Reference data were used for this field.	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2020**
	Field Note: Reference data were used for this field.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Reference data were used to generate this field.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Reference data were used to generate this field.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Reference data were used to generate this field.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Reference data were used to generate this field.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Reference data were used to generate this field.	

Data Alerts:

1.	Pregnant Women, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
3.	Children 1 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
4.	Children with Special Health Care Needs 0 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Virgin Islands

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	973	64	713	4	0	0	0	0	192
Title V Served	5,363	0	0	0	0	0	0	0	5,363
Eligible for Title XIX	10,907	0	0	0	0	0	0	0	10,907
2. Total Infants in State	973	64	713	4	0	0	0	0	192
Title V Served	973	64	713	4	0	0	0	0	192
Eligible for Title XIX	10,907	64	713	4	0	0	0	0	10,126

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Virgin Islands

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(866) 248-4004	(866) 248-4004
2. State MCH Toll-Free "Hotline" Name	MCH Program	MCH Program
3. Name of Contact Person for State MCH "Hotline"	Kim Christopher	Kim Chrisopher
4. Contact Person's Telephone Number	(340) 777-8804	(340) 777-8804
5. Number of Calls Received on the State MCH "Hotline"		110

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	healthvi.org	
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Virgin Islands

1. Title V Maternal and Child Health (MCH) Director	
Name	Charmaine Mayers
Title	MCH Director
Address 1	3241 Estate Contant 78-1, 2 & 3
Address 2	
City/State/Zip	St. Thomas / VI / 00802
Telephone	(340) 777-8804
Extension	2706
Email	charmaine.mayers@doh.vi.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Charmaine Mayers
Title	MCH Director
Address 1	3241 Estate Contant 78-1,2 &3
Address 2	
City/State/Zip	St. Thomas / VI / 00802
Telephone	(340) 777-8804
Extension	2706
Email	charmaine.mayers@doh.vi.gov

3. State Family or Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Virgin Islands

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increase the number of women that have well women visits	Continued
2.	Increase the number of families educated on safe sleep practices	Continued
3.	Decrease the number of children with BMI>85%	Continued
4.	Increase the percent of developmental screenings done in the territory	Continued
5.	Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents	Continued
6.	Increase percentage of families that participate in transition planning	Continued
7.	Increase access to oral health care for the Maternal Child health population	Continued
8.	Increase the number of women breastfeeding up to six months	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increase the number of women that have well women visits	Continued
2.	Increase the number of families educated on safe sleep practices	Continued
3.	Decrease the number of children with BMI>85%	Continued
4.	Increase the percent of developmental screenings done in the territory	Continued
5.	Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents	Continued
6.	Increase percentage of families that participate in transition planning	Continued
7.	Increase access to oral health care for the Maternal Child health population	Continued
8.	Increase the number of women breastfeeding up to six months	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Virgin Islands

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	61.3 %	2.0 %	348	568
2015	58.8 %	2.2 %	292	497

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	85.5 %	13.7 %	1,674	1,958

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	862.4
Numerator	84
Denominator	974
Data Source	Hospital Nurse Liaison Report
Data Source Year	2020

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	974
Data Source	Hospital Nurse Liaison Reports
Data Source Year	2020

NOM 3 - Notes:

None

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 3. Please review your data to ensure this is correct.

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.9 %	1.0 %	92	930
2015	9.2 %	0.8 %	114	1,238
2012	9.6 %	0.8 %	133	1,386
2011	10.4 %	0.8 %	152	1,463
2010	9.0 %	0.7 %	141	1,570
2009	9.5 %	0.7 %	159	1,670

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.6 %	3.7 %	3,946	27,026

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.2 %	1.0 %	88	862
2015	10.6 %	1.0 %	110	1,039
2012	12.7 %	0.9 %	172	1,359
2011	11.5 %	0.8 %	166	1,442
2010	10.7 %	0.8 %	167	1,560
2009	9.9 %	0.7 %	165	1,663

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	15.1 %	3.4 %	4,085	27,026

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	32.0 %	1.6 %	276	862
2015	34.2 %	1.5 %	355	1,039
2012	30.5 %	1.3 %	414	1,359
2011	31.1 %	1.2 %	449	1,442
2010	29.4 %	1.2 %	458	1,560
2009	32.6 %	1.2 %	542	1,663

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016/Q3-2017/Q2	10.0 %			
2016/Q2-2017/Q1	10.0 %			
2016/Q1-2016/Q4	6.0 %			
2015/Q4-2016/Q3	5.0 %			
2015/Q3-2016/Q2	10.0 %			
2015/Q2-2016/Q1	10.0 %			
2015/Q1-2015/Q4	11.0 %			
2014/Q4-2015/Q3	11.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	5.0 %			
2014/Q1-2014/Q4	7.0 %			
2013/Q4-2014/Q3	6.0 %			
2013/Q3-2014/Q2	10.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.0	2.9	12	1,198
2015	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	8.7	2.4	13	1,497
2010	13.6	2.9	22	1,615
2009	12.9	2.8	22	1,700

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2012	8.5	2.5	12	1,415
2011	8.0	2.3	12	1,491
2010	9.4	2.4	15	1,600
2009	7.1	2.1	12	1,687

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	6.7	2.1	10	1,491
2010	6.3	2.0	10	1,600
2009	6.5	2.0	11	1,687

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	974
Data Source	Hospital Nurse Liaison Report
Data Source Year	2020

NOM 10 - Notes:

None

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 10. Please review your data to ensure this is correct.

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	974
Data Source	Hospital Nurse Liaison Report
Data Source Year	2020

NOM 11 - Notes:

None

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 11. Please review your data to ensure this is correct.

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	12.3 % ϟ	3.7 % ϟ	3,214 ϟ	26,127 ϟ

Legends:

ϟ Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2012	95.0	27.4	12	12,630
2011	NR	NR	NR	NR
2010	107.4	27.7	15	13,964
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
2008_2010	NR	NR	NR	NR
2007_2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
2008_2010	NR	NR	NR	NR
2007_2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	13.1 %	2.8 %	3,554	27,026

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.8 %	4.9 %	385	3,554

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.4 %	1.3 %	542	23,011

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.7 %	1.4 %	620	23,011

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	55.2 %	12.1 %	500	904

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	83.4 %	3.4 %	22,536	27,026

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	15.1 %	1.1 %	165	1,094
2016	13.1 %	0.9 %	209	1,593
2014	11.9 %	0.8 %	216	1,816
2012	12.9 %	0.7 %	275	2,138
2010	12.4 %	0.7 %	259	2,093
2008	15.4 %	0.9 %	262	1,703

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS) - Age 10-17

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	27.6 %	4.6 %	3,418	12,376

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.7 %	3.1 %	3,155	27,026

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	39.4 %	4.5 %	1,000	1,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	38.2 %	2.4 %	9,018	23,594
2015_2016	39.8 %	1.8 %	9,401	23,603
2014_2015	40.9 %	2.1 %	9,732	23,790

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	48.8 %	4.5 %	3,350	6,860
2016	41.9 %	2.9 %	3,030	7,240
2015	37.9 %	2.7 %	2,738	7,230

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	79.2 %	3.6 %	5,433	6,860
2016	78.9 %	2.4 %	5,710	7,240
2015	82.0 %	2.0 %	5,930	7,230
2013	76.4 %	2.6 %	5,671	7,420
2012	72.0 %	2.3 %	5,400	7,499
2011	63.5 %	2.6 %	4,987	7,859
2010	62.8 %	3.7 %	5,758	9,172
2009	34.9 %	3.2 %	3,469	9,953

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	75.0 %	3.7 %	5,145	6,860
2016	61.3 %	2.9 %	4,435	7,240
2015	56.1 %	2.7 %	4,052	7,230
2013	38.4 %	3.1 %	2,848	7,420
2012	38.1 %	2.5 %	2,854	7,499
2011	31.5 %	2.5 %	2,478	7,859
2010	32.0 %	3.8 %	2,930	9,172
2009	21.1 %	2.7 %	2,097	9,953

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	25.4	2.9	79	3,106
2015	33.1	3.2	107	3,231
2012	37.6	3.2	141	3,754
2011	53.1	3.7	207	3,897
2010	46.3	3.4	187	4,043
2009	53.4	3.6	217	4,067

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	974
Data Source	Hospital Nurse Liaison Report
Data Source Year	2020

NOM 24 - Notes:

None

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 24. Please review your data to ensure this is correct.

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.0 %	2.4 %	2,704	27,026

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Virgin Islands

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		61
Annual Indicator	76.6	76.6
Numerator	14,873	14,873
Denominator	19,410	19,410
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	25	40	43	59	61
Annual Indicator	38.5	55.2	57.9	76.6	76.6
Numerator	2,275	2,992	2,986	14,873	14,873
Denominator	5,903	5,419	5,154	19,410	19,410
Data Source	Family Planning and FQHCs	Family Planning and FQHCs	Fam. Planning and FQHCs	MCH-JS	MCH-JS
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	62.0	64.0	65.0	67.0	68.0	68.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	62	85	62	63
Annual Indicator	85.9	83.9	83.9	83.9
Numerator	1,021	880	880	880
Denominator	1,189	1,048	1,048	1,048
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2015	2015

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	62	63
Annual Indicator	86.0	86.0
Numerator	7,734	7,734
Denominator	8,989	8,989
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	85	62	85	62	63
Annual Indicator	61.6	50.8	61.2	19.7	19.7
Numerator	597	423	398	971	971
Denominator	969	832	650	4,925	4,925
Data Source	WIC	WIC	WIC	WIC	WIC
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	63.0	65.0	65.0	66.0	66.0	66.0

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	11	85	13	13
Annual Indicator	18.3	19.9	19.9	19.9
Numerator	211	204	204	204
Denominator	1,152	1,024	1,024	1,024
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2015	2015

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	85	11	85	13	13
Annual Indicator	10.7	13.2	12.2	86	86
Numerator	104	110	79	7,734	7,734
Denominator	969	832	650	8,989	8,989
Data Source	WIC	WIC	WIC	MCH-JS	MCH-JS
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Provisional	Provisional	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	14.0	14.0	15.0	16.0	16.0	16.0

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	22	25
Annual Indicator	64.1	64.1
Numerator	576	576
Denominator	899	899
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	60	30	80	22	25
Annual Indicator	60	80	20.8	64.1	64.1
Numerator	30	40	5	576	576
Denominator	50	50	24	899	899
Data Source	MIECHV	MIECHV	MIECHV	MCH-JS	MCH-JS
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	25.0	27.0	30.0	32.0	32.0	33.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The information reported for this performance measure is collected solely from the MIECHV program. The denominator represents the portion of total children served who were under the age of one in 2018. The numerator represents the number of those children whose parent answered affirmatively to a question that the child slept on an approved surface, without soft objects or loose bedding and on their backs.

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2017	2018	2019	2020
Annual Objective			22	25
Annual Indicator	80	20.8	64.1	64.1
Numerator	40	5	576	576
Denominator	50	24	899	899
Data Source	MIECHV	MIECHV	MCH-JC	MCH-JS
Data Source Year	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	27.0	30.0	32.0	32.0	33.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The information reported for this performance measure is collected solely from the MIECHV program. The denominator represents the portion of total children served who were under the age of one in 2018. The numerator represents the number of those children whose parent answered affirmatively to a question that the child slept on an approved surface, without soft objects or loose bedding and on their backs.

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2017	2018	2019	2020
Annual Objective			22	25
Annual Indicator	64	20.8	73.7	34.8
Numerator	32	5	14	8
Denominator	50	24	19	23
Data Source	MIECHV	MIECHV	MIECHV	MIECHV
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	27.0	30.0	32.0	32.0	33.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The information reported for this performance measure is collected solely from the MIECHV program. The denominator represents the portion of total children served who were under the age of one in 2018. The numerator represents the number of those children whose parent answered affirmatively to a question that the child slept on an approved surface, without soft objects or loose bedding and on their backs.

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	53	55
Annual Indicator	13.2	13.2
Numerator	450	450
Denominator	3,422	3,422
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			33	53	55
Annual Indicator	100	22.7	53.6	13.2	13.2
Numerator	30	85	374	450	450
Denominator	30	374	698	3,422	3,422
Data Source	MIECHV	MIECHV	MIECH and Title V Special Pediatrics	MCH-JS	MCH-JS
Data Source Year	2017	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	58.0	60.0	62.0	65.0	65.0	65.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
The population of children receiving developmental screening increased significantly with the addition of a contracted neurologist within Title V clinics. Title V simultaneously adapted the best practice of providing developmental screening to all children in the appropriate age group regardless of visit type.

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD		
	2019	**2020**
Annual Objective	30	32
Annual Indicator	72.5	72.5
Numerator	6,568	6,568
Denominator	9,054	9,054
Data Source	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			36	30	32
Annual Indicator	30.2	30.2	30.2	72.5	72.5
Numerator	2,484	2,484	2,484	6,568	6,568
Denominator	8,237	8,237	8,237	9,054	9,054
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	MCH-JS	MCH-JS
Data Source Year	2011_2012	2011_2012	2011_2012	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	32.0	33.0	33.0	34.0	34.0	35.0

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	65	65
Annual Indicator	67.7	67.7
Numerator	6,085	6,085
Denominator	8,984	8,984
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			71	65	65
Annual Indicator	65.2	65.2	65.2	67.7	67.7
Numerator	6,103	6,103	6,103	6,085	6,085
Denominator	9,355	9,355	9,355	8,984	8,984
Data Source	NSCH	NSCH	NSCH	MCH-JS	MCH-JS
Data Source Year	2011_2012	2011_2012	2011_2012	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	67.0	67.0	68.0	68.0	69.0	70.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	37.4	37.4
Numerator	1,329	1,329
Denominator	3,554	3,554
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data		
	2019	**2020**
Annual Objective		
Annual Indicator	37.4	37.4
Numerator	1,329	1,329
Denominator	3,554	3,554
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	38.0	38.0	39.0	40.0	41.0	41.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	46	48
Annual Indicator	46.0	46.0
Numerator	12,017	12,017
Denominator	26,127	26,127
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			57	46	48
Annual Indicator	37.8	37.8	45	46	46
Numerator	4,116	4,116	7,949	12,017	12,017
Denominator	10,888	10,888	17,650	26,127	26,127
Data Source	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS DATA	MCH-JS	MCH-JS
Data Source Year	2017	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.0	52.0	54.0	57.0	57.0	58.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data for age categories for NPM 13.2 is not available. UDS data for oral exams, all adults and children, has been substituted for this measure.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data for age categories for NPM 13.2 is not available. UDS data for oral exams, all adults and children, has been substituted for this measure. There may be some overlap between the data presented by the FQHCs for oral exams, prophylaxis and sealants.	

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Virgin Islands

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective	25	26
Annual Indicator	62.3	62.3
Numerator	852	852
Denominator	1,366	1,366
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			31	25	26
Annual Indicator	24.9	24.9	24.9	62.4	
Numerator	212	212	212	852	
Denominator	850	850	850	1,366	
Data Source	NS-CSHCN	NSCH	NSCH	MCH-JS	
Data Source Year	2009_2010	2009_2010	2009_2010	2019	
Provisional or Final ?	Final	Final	Final	Final	

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	46	48
Annual Indicator	46.0	46.0
Numerator	12,017	12,017
Denominator	26,127	26,127
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			38	46	48
Annual Indicator	37.8	37.8	45	76.9	21.1
Numerator	4,116	4,116	7,949	8,357	2,509
Denominator	10,888	10,888	17,650	10,868	11,899
Data Source	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS Data, MCH and DOE	USVI FQHC UDS
Data Source Year	2017	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data for age categories for NPM 13.2 is not available. UDS data for oral exams, all adults and children, has been substituted for this measure.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data for age categories for NPM 13.2 is not available. UDS data for oral exams, all adults and children, has been substituted for this measure. There may be some overlap between the data presented by the FQHCs for oral exams, prophylaxis and sealants.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The numerator reflects clients (child and adult) receiving the following types of dental services: oral exams; prophylaxis; sealants; and fluoride treatments. Excluded from the numerator were the following services: emergency services; restorative services; oral surgery; and rehabilitative services. The numerator represents all clients served by the two FQHCs in the Territory during calendar year 2020.	

Form 10
State Performance Measures (SPMs)

State: Virgin Islands

SPM 1 - Increase the percentage of pregnant women who enroll in prenatal care in the first trimester.

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019	2020
Annual Objective			58	50	50
Annual Indicator	57.2	49.9	46.8	59.2	60.2
Numerator	667	487	457	660	586
Denominator	1,167	975	976	1,114	974
Data Source	Hospitial Liaison Nurse Report	Hospital Liaison Nurse Report	Hospital Liaison Report	Hospital Statistics and MCH	Hospital Liaison Nurse and FQHC DataReport
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	51.0	50.0	52.0	54.0	54.0	65.0

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2020**

   Column Name: **State Provided Data**

   Field Note:
   Data for the numerator reflect numbers from the St. Croix District MCH Clinical report for FY2019-2020 and from the St. Thomas-St. John District FQHC, STEEMCC UDS for CY2019, the most current data available.

SPM 2 - The percent of CSHCN clients who access family support services.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		80	80	74	78
Annual Indicator	78.2	79.2	71.1	32.4	32.4
Numerator	1,167	993	849	477	477
Denominator	1,493	1,254	1,194	1,471	1,471
Data Source	MCH Clinic and Allied Health Services	MCH Clinic and Allied Health	MCH Clinic, Allied Health and Medicaid	MCH and Zero to Three	MCH and Zero to three
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Provisional	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	81.0	82.0	83.0	83.0	83.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Social Worker position for St. Croix vacant.

SPM 3 - Increase access to comprehensive primary and preventive health care for adolescents and pre-adolescents ages 10-19 years.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		22	25	25	25
Annual Indicator	22.1	21.1	17.7	31.4	19.9
Numerator	2,611	2,492	2,086	3,412	2,185
Denominator	11,803	11,803	11,803	10,868	10,981
Data Source	MCH and FQHCs	MCH and FQHCs/Community Survey	FQHCs/Community Survey	FQHC, MCH and DOH	MCH FQHCs
Data Source Year	2016	2017	2018/2013	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.0	28.0	30.0	31.0	31.0	33.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Annual indicator is derived by a numerator which includes MCH and FQHC data divided by a denominator derived by the Virgin Islands Community Survey (census).	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The denominator is the total adolescent and pre-adolescent population (10-19 years of age) based on the most recent Virgin Islands Community Survey (2015) completed by the University of the Virgin Islands. Virgin Islands Community Surveys for 2016 and 2018 are expected over the next two months. 2020 Census data are not yet available.	

SPM 4 - Increase access to oral health care services for the child and adolescent MCH populations.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			30	33
Annual Indicator		8.8	8.9	7.2
Numerator		971	965	838
Denominator		11,000	10,868	11,589
Data Source		FQHCs Data	FQHCs Data	FQHC Data VIDE School HS EHS Enrollment
Data Source Year		2018	2019	2019 2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	34.0	36.0	36.0	40.0	40.0	40.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: These data reflect only FQHC data for children 6-9 years old only. Data were not disaggregated for other age categories for the MCH population (birth through 21 years of age).	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Head Start and Early Head Start PIR data for SY2018-2019 (most recent available data) regarding dental exams or dental home and FQHC data relative to dental sealants for MCH population (children 6-9). The denominator represents the school enrollment for SY2019-2020 and the HS/EHS enrollment for SY2018-2019.	

Form 10
State Outcome Measures (SOMs)

State: Virgin Islands

SOM 1 - Percentage of pregnant women who receive prenatal care beginning in the first trimester

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	85.5	
Numerator	1,674	
Denominator	1,958	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.5	90.0	91.0	92.0	93.0	93.0

Field Level Notes for Form 10 SOMs:

None

SOM 2 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.2	
Numerator	3,554	
Denominator	27,026	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2021	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.1	13.5	14.0	15.0	15.0	15.0

Field Level Notes for Form 10 SOMs:

None

SOM 3 - Percent of children , ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	55.3	
Numerator	500	
Denominator	904	
Data Source	MCH Jurisdictional Survey	
Data Source Year	2021	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.3	56.0	57.0	58.0	60.0	62.0

Field Level Notes for Form 10 SOMs:

None

SOM 4 - Percentage of Children, ages 1 through 17, who have decayed teeth or cavities in the past year

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	12.3	
Numerator	3,214	
Denominator	26,127	
Data Source	National Survey of Childrens Health	
Data Source Year	2019	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	11.0	10.0	9.5	8.0	7.5	7.0

Field Level Notes for Form 10 SOMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Virgin Islands

ESM 1.1 - Percentage of women in Title X sites receiving preconception services.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		41	43	89	89
Annual Indicator	40.6	47.4	87.4	35.8	87.9
Numerator	1,087	1,193	1,579	842	2,587
Denominator	2,677	2,516	1,806	2,349	2,943
Data Source	Family Planning	Family Planning	Family Planning	MCH	Family Planning
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	90.0	90.0	91.0	92.0	92.0	92.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Percent of infants ever breastfed

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			62
Annual Indicator		85.9	44.5
Numerator		79	433
Denominator		92	974
Data Source		MIECHV and MCH-JS	Nurse Liaison Report and VI State Plan WIC
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	63.0	63.0	65.0	66.0	66.0	67.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Please note that these data reflect WIC reporting on number of children breastfed during FY2019-2020. The denominator reflects total births in the Territory for FY2019-2020, based on the Hospital Nurse Liaison Report for the same fiscal year. The data reported for 2019 captured only MIECHV and the MCH-JS data, so are not comparable to data provided for 2020.

ESM 5.1 - Percent of families receiving safe sleep educational materials at District birthing hospitals.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			70
Annual Indicator		95.5	100
Numerator		1,064	974
Denominator		1,114	974
Data Source		Hospital Statistics	Hospital Liaison Nurse Report
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	75.0	78.0	80.0	85.0	85.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - Children receiving a developmental screening using a parent-completed screening tool.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			55
Annual Indicator		86.3	82.2
Numerator		164	217
Denominator		190	264
Data Source		Zero to Three and MIECHV	Zero to Three and MIECHV
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	58.0	60.0	62.0	65.0	65.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.1 - Physical activity counseling during the well-child visit within the MCH population.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		50	58	68	70
Annual Indicator	49.7	57.3	66.4	79.1	27.9
Numerator	1,265	1,787	2,671	8,595	628
Denominator	2,547	3,120	4,020	10,868	2,247
Data Source	FQHC Data	FQHC Data	FQHC and MCH Clinics	DOE	FQHCs
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	70.0	72.0	74.0	74.0	74.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: MCH clinics were added to the data source for calendar year 2018. Both the population and performance improved. We will be monitoring to observe trend data on the reported levels of physical activity and BMI levels.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data are captured from Section E of the USVI FQHC UDS for 2020 -- Weight Assessment and counseling for nutrition and physical activity of children and adolescents. Patient age range: 3 -16, inclusive. Numerator reflects children and adolescents assessed and counseled. 2,247 represents the total number of patients 3 - 16 years of age, inclusive.	

ESM 10.1 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			5
Annual Indicator		63	1.6
Numerator		6,848	178
Denominator		10,868	10,907
Data Source		DOE	MCH EDHI and VIDE school enrollment
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	15.0	20.0	25.0	65.0	65.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The numerator for this indicator reflects school visit numbers. Visits began in fall 2019 and were schedule to continue in March 2020. However, due to school closures in March 2020 because of the COVID-19 pandemic, all face-to-face school visits were suspended. The denominator reflects the total public school enrollment for SY2019-2020. The Title V Program will redouble its efforts for school visits once in person instruction resumes in the public schools, with a focus on elementary grades.

ESM 11.1 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	37.4	42.7
Numerator	1,329	1,110
Denominator	3,554	2,599
Data Source	VI	MCH Clinic Data and MCH-JS
Data Source Year	VI	2019 2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	38.0	38.0	40.0	41.0	42.0	44.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - Percent of Children, ages 1-17, who have had Preventive Dental Health visit in the past year

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			46	48
Annual Indicator		8.8	8.9	21.1
Numerator		971	965	2,509
Denominator		11,000	10,868	11,899
Data Source		FQHCs Data	FQHCs Data and DOE	USVI FQHC UDS HS/EHS PIR
Data Source Year		2018	2019	2019 2020
Provisional or Final ?		Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	54.0	57.0	48.0	48.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 12.1 - Use of evidenced-based health care transition tools in public health and FQHC facilities.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1	1	1	1
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	MCH Program	MCH Program	MCH Program	MCH program	MCH and CSHCN Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Although evidence-based transition tool was selected to be recommended for use in public health and FQHCs, the initial discussions are still pending. Thereafter, implementation will take place. Title V will work to support the implementation in public health and FQHCs.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Although evidence-based transition tool was selected to be recommended for use in public health and FQHCs, the initial discussions are still pending. In calendar year 2018, the focus for public health and FQHCs was that of recovery and the provision of basic healthcare services. Title V will renew its efforts to ensure the use of evidence-based transitional care in the MCH population through the adaptation of and evidence-based tool.

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Due to challenges related to recovery from Hurricanes Irma and Maria, and the additional challenges that the Territory has been facing with the COVID-19 Pandemic, it has been necessary to temporarily suspend work on the measure. However, the Territory remains committed to implementing evidence-based transition tools and hope to begin this process in earnest in FY2021-2022.

2016-2020: ESM 13.2.2 - Increase access to dental health services through inter-agency partnerships and supportive services such as provider training and resources.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			2	2	2
Annual Indicator	0	1	0	1	1
Numerator					
Denominator					
Data Source	Title V Program	Title V Program	Title V Program	Title V Program	Title V Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: In partnership with the Association of State and Territorial Dental Directors, Title V will be conducting an oral health needs assessment of existing oral health services to determine capacity and unmet needs.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The MCH & CSHCN had Oral Health outreach in conjunction with the American Dental Association in February 2020. Oral health services will be implemented in FY2021-2022, beginning with a training for clinical staff to apply varnish. Further, oral health will be incorporated in well-child visit. Additionally, in FY2021-2022, the MCH & CSHCN Program plans to collaborate with the Territory's FQHCs to increase the number of children who receive sealants as a means of reducing dental caries in the MCH population.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Virgin Islands

SPM 1 - Increase the percentage of pregnant women who enroll in prenatal care in the first trimester.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Reduce barriers and increase access to early and adequate prenatal care that ensures healthy birth outcomes.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women receiving early and adequate prenatal care in the first trimester. **Denominator:** Number of singleton births.
Data Sources and Data Issues:	Hospital Labor & Delivery Units; Newborn Nurseries; Bureau of Health Statistics live birth records; MCH, FQHC and Community Health Prenatal Clinics.
Significance:	Access to early and adequate prenatal care results in improved birth outcomes if women begin receiving care early in pregnancy and continue to receive care throughout the pregnancy. Prenatal care provides an opportunity to identify risks and minimize or eliminate their impact on pregnancy outcomes through medical management so it does not negatively impact on maternal health, birth outcomes and the process of birth. Prenatal visits also offer an opportunity for education and counseling on proper nutrition and risk factors, such as smoking and alcohol use during pregnancy.

SPM 2 - The percent of CSHCN clients who access family support services.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase to 50% the number of families with CSHCN who are referred to and receive various family support services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN clients ages 0-21 years whose families access family support services. **Denominator:** Total number of CSHCN clients served.
Data Sources and Data Issues:	VIDOH EHR, MCH & CSHCN clinic records. Community Health Centers. Community based family support organizations and the Dept of Human Services.
Significance:	Family service agencies and interagency coordinating councils have identified major challenges confronting families with CSHCN in accessing coordinated health and related services. Addressing these issues will lead to more efficient use of public funds and reduce family stress. Included in community-based settings are public facilities; local government and agencies; and social service, faith, and civic organizations that provide access to families where they live, work, and play.

SPM 3 - Increase access to comprehensive primary and preventive health care for adolescents and pre-adolescents ages 10-19 years.
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To assure access to primary care services for adolescents and pre-adolescents ages 10-19 years of age.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of adolescents and pre-adolescents age 10-19 years with a specific source of primary care.</td></tr>
<tr><td>Denominator:</td><td>Number of adolescents and pre-adolescents age 10-19 years.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MCH, Community Health and 330 FQHC's clinic utilization data. Data issues related to lack of data linkages between provider facilities and standardized methods of data collection and reporting.</td></tr>
<tr><td>Significance:</td><td>A usual source of primary care helps people clarify the nature of their health problems and can direct them to appropriate health services, including specialty care.[44] Primary care also emphasizes continuity, which implies that individuals use their primary source of care over time for most of their health care needs.</td></tr>
</table>

SPM 4 - Increase access to oral health care services for the child and adolescent MCH populations.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase percentage of children and adolescents receiving preventative oral healthcare services by 5%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Children and adolescents, ages 1-17 that access care at FQHC dental clinics **Denominator:** Total number of children and adolescents ages 1-17
Data Sources and Data Issues:	FQHC clinics, UDS Report
Significance:	1 The health of the teeth, the mouth, and the surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral health care is associated with factors such as education level, income, race, and ethnicity. 1 Healthy People 2020

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Virgin Islands

SOM 1 - Percentage of pregnant women who receive prenatal care beginning in the first trimester
Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health

Measure Status:	Active
Goal:	To ensure early entrance into prenatal care to enhance pregnancy outcomes
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of live births with reported first prenatal visit during the first trimester (before 13 weeks gestation) in the calendar year **Denominator:** Number of live births
Data Sources and Data Issues:	National Vital Statistics Systems
Significance:	Early prenatal care is essential for identification of maternal disease and risks for complication of pregnancy or birth.

SOM 2 - Percent of children with special health care needs (CSHCN), ages 0 through 17
Population Domain(s) – Child Health, Adolescent Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	To track the percent of children and youth with special health care need, autism spectrum disorder (ASD) and attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children, ages 0 through 17, who met the criteria for having a special health care need based on the CSHCN screener **Denominator:** Number of children of children ages 0 through 17
Data Sources and Data Issues:	MCH Jurisdictional Survey, National Vital Statistics System
Significance:	Children are considered to have a special health care need if, in addition to a chronic medical, behavioral or developmental condition that has lasted or is expected to last 12 months or longer, they experience either service-related or functional consequences including the need for or use of prescription medications and/or specialized therapies.

SOM 3 - Percent of children , ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	To increase the percent of children with a mental/behavioral condition who receive treatment or counseling
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of children ages 3 through 17 , reported by their parents to have been diagnosed by a health care provider with a mental/behavioral condition (depression, anxiety problems, or behavioral or conduct problems) who currently have the condition</td></tr><tr><td>**Denominator:**</td><td>Number of children ages 3 through 17, reported by their parents to have been diagnosed by a health care provider, with a mental/behavioral condition (depression, anxiety problems, or behavioral or conduct problems) who currently have the condition</td></tr></table>
Data Sources and Data Issues:	National survey of Children's Health (NSCH)
Significance:	The prevalence of mental/behavioral health conditions has been increasing among children and has been found to vary by geographic and sociodemographic factors. However a significant portion of children diagnosed with a mental health condition do not receive treatment

SOM 4 - Percentage of Children, ages 1 through 17, who have decayed teeth or cavities in the past year
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To reduce the percent of children and adolescents who have dental caries or decayed teeth
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children ages 1 through 17 who have decayed teeth r cavities in the past year **Denominator:** Number of children, ages 1 through 17
Data Sources and Data Issues:	Nation Survey of Children's Health (NSCH)
Significance:	Tooth decay (cavities) is among the most chronic conditions of childhood. Untreated tooth decay can lead to pain and infections which may result in problems with eating, speaking, learning and playing

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Virgin Islands

ESM 1.1 - Percentage of women in Title X sites receiving preconception services.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the percent of women receiving preconception services through family planning clinics.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women receiving preconception services through family planning clinics in the past year. **Denominator:** Number of women accessing services through family planning clinics.
Data Sources and Data Issues:	Community Health Clinic; Family Planning Clinics
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

ESM 4.1 - Percent of infants ever breastfed
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase through education on the benefits of breastfeeding, the percentage of infants who are ever breastfed.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 544 **Denominator:** 640
Data Sources and Data Issues:	WIC Infants
Significance:	Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. Pediatrics. 2012 Mar;129(3):e827-41. http://pediatrics.aappublications.org/content/early/2012/02/22/peds.2011-3552

ESM 5.1 - Percent of families receiving safe sleep educational materials at District birthing hospitals.
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	To increase safe sleep educational awareness to families through materials and resources distributed at District hospitals.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 303 **Denominator:** 976
Data Sources and Data Issues:	Title V Program
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the AAP has long recommended the back (supine) sleep position. However, in 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Among others, additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.

ESM 6.1 - Children receiving a developmental screening using a parent-completed screening tool.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase the percent of children receiving developmental screening using a parent-completed tool.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 100 **Denominator:** 200
Data Sources and Data Issues:	Title V pediatric and specialty clinics.
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006 Jul;118(1):405-20. http://pediatrics.aappublications.org/content/118/1/405

ESM 8.1.1 - Physical activity counseling during the well-child visit within the MCH population.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Partner with the FQHC's to increase the physical activity counseling that occurs during the well child visit visit.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of chlildren that received physical activity counseling during their well child visit within the past year. **Denominator:** Number of children seen by FQHC's for a well child visit during the past year.
Data Sources and Data Issues:	Title V Program
Significance:	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

ESM 10.1 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase the percentage of students receiving school based preventive health care services in the school setting.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 590 **Denominator:** 11803
Data Sources and Data Issues:	Title V Program
Significance:	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. The Bright Futures guidelines recommends that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health-related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.

ESM 11.1 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To ensure that all children with or without special healthcare needs are able to identify a medical home
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 9758 **Denominator:** 27026
Data Sources and Data Issues:	Jurisdictional Survey
Significance:	Meeting the needs of the targeted population

ESM 13.2.1 - Percent of Children, ages 1-17, who have had Preventive Dental Health visit in the past year
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	60
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Children who have had an preventive dental visit in the past year **Denominator:** All children 0-17
Data Sources and Data Issues:	FQHC DATA
Significance:	Dental

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 12.1 - Use of evidenced-based health care transition tools in public health and FQHC facilities.
2016-2020: NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the use of an evidenced-based health care transition tool for transition readiness assessment in public health and FQHC facilities.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>4</td></tr>
<tr><td>Numerator:</td><td>Number of public health and FQHC facilities using an evidenced-based health care transition toll for transition readiness assessments.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Title V Program; FQHCs</td></tr>
<tr><td>Significance:</td><td>The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.</td></tr>
</table>

2016-2020: ESM 13.2.2 - Increase access to dental health services through inter-agency partnerships and supportive services such as provider training and resources.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Form inter-agency partnerships with FQHCs to improve coordination between dental and other health services.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>2</td></tr>
<tr><td>Numerator:</td><td>Number of inter-agency partnerships implemented to coordinate dental and other health services.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Title V Program</td></tr>
<tr><td>Significance:</td><td>Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</td></tr>
</table>

Form 11
Other State Data

State: Virgin Islands

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Virgin Islands

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	No	Annually	12		
2) Vital Records Death	Yes	No	Annually	12	No	
3) Medicaid	Yes	No	Annually	6	No	
4) WIC	Yes	No	Annually	6	No	
5) Newborn Bloodspot Screening	Yes	No	Monthly	1	No	
6) Newborn Hearing Screening	Yes	Yes	Daily	1	No	
7) Hospital Discharge	Yes	No	Annually	2	No	
8) PRAMS or PRAMS-like	No	No	Never	NA	No	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) FQHC UDS Data	Yes	Yes	Annually	8	No	
10) HS/EHS PIR Data	Yes	Yes	Annually	18	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None