

**Maternal and Child  
Health Services Title V  
Block Grant**

**Virgin Islands**

**FY 2016 Application/  
FY 2014 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 OF HEALTH  
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July 10, 2015

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Michelle Lawler, Director  
Division of State and Community Health  
Maternal Child Health Bureau  
5600 Fisher's Lane  
Parklawn Building, Room 18-31  
Rockville, MD 20857

Dear Ms. Lawler:

This letter of transmittal is for the formal application from the Territory of the Virgin Islands, Department of Health, to participate in the Maternal Child Health Services Block Grant for Fiscal Year 2016, as authorized by Title V of the Social Security Act (as amended by Public Law 97-35, 100-72 and 100-93). It complies with the notification requirements of the Omnibus Budget Reconciliation Act of 1989.

The Maternal Child Health Services Title V Block Grant Program Guidance and forms for the FY'2016 Application and FY'2014 Annual Report and the new WEB based TVIS for electronic submission were fully utilized.

We look forward to your favorable approval of this document.

Sincerely,

  
Phyllis Wallace, Ed.D., M.S.  
Commissioner Nominee

PW/mo

## **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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

## **I.E. Application/Annual Report Executive Summary**

The Title V Maternal and Child Health Services Block Grant Program is operated as a single Administrative Unit within the Department of Health. Throughout FY '14, the MCH & CSHCN Program continued to promote care coordination and collaboration among programs serving the special needs population. Outreach, education and case management activities for pregnant women were provided through MCH Public Health Nurses, Home Visitors and Nurses under the Maternal, Infant, and Early Childhood Program, and in collaboration with various community partners.

Partners and collaborators who were actively engaged with the program to maximize sharing of resources included individuals from the Departments of Education, 330-funded Community Health Centers, Medical Assistance Program, WIC Program, Vital Statistics, Immunization, Family Planning, Nursing Services, Social Services, Infants and Toddlers Program, Community Partners, and Parent Advocates. Parent and consumer participation and involvement via the MCH Advisory Council is being strengthened.

The MCH & CSHCN Program focuses on the well being of the MCH populations of women and infants, children and adolescents, and children with Special Health Care needs (CSHCN) and their families. The program places an emphasis on developing core public health functions and responding to changes in the health care delivery system. As a territory with significant shortages of pediatric medical services and limited existing services, the Virgin Islands faces many challenges to development of systematic approaches to population based direct care services. In the past few years, program activities addressed improvement of access to services low-income, underserved or uninsured families, identification of the needs of culturally diverse groups, especially non-English speaking and other immigrant groups, and recognition of changes brought about by lack of access to adequate health insurance coverage, public or private, for a significant percentage of the population. In addition, activities for children and youth with special health care needs focused on assuring pediatric specialty and sub-specialty services to children and families, integrating data systems, continuing collaborations with private and public partnerships, and integrating community based services.

The Virgin Islands MCH & CSHCN has identified the following top 8 priority needs for primary and preventive care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for children with special health care needs.

National Performance Measure #	National Performance Priority Areas	MCH Population Domains
1	Well-woman visit	Women/Maternal Health
4	Breastfeeding	Perinatal/Infant Health
5	Safe sleep	Perinatal/Infant Health
6	Developmental Screening	Child Health
8	Physical activity	Child Health and/or Adolescent Health
8	Adolescent well-visit	Adolescent Health
10	Transition	Children with Special Health Care Needs
12	Oral Health	Cross-cutting/ Life Course

### Emergent Needs

A system of care is achievable as we have brought to the forefront and are addressing major issues, i.e., the need for focused adolescent healthcare services; comprehensive support services for children and families of children with special health care needs; healthy birth outcomes for all pregnant women, especially of low income, and decreased health disparities in segments of the population. MCH Program Administrator working in concert with Practitioners and Advisory Council member will receive a full orientation on the Five-Year Plan. Work groups comprised of the individuals in these categories will be formed to assume responsibility for segments of the Plan and a recording and reporting system will be used to monitor and evaluate progress.

Another key area to MCH & CSHCN effective system of care is the continuance of improved access to Direct Health Services. This occurs at multiple levels of performance such as extending hours and increasing number of service delivery sites in both health service districts; extend hours for prenatal clinics to accommodate working mothers, particularly in the private sector; increase services to adolescents in all areas of primary and preventive care appropriate for this age group; and, continue to provide primary and preventive care services to mothers.

Both Enabling Services and Population Based Services require systematic, concurrent enhancement of the department's visibility and conceptual position of local citizens. Therefore, comprehensive awareness campaigns are being instituted for all Department of Health providers, collaborative government agencies, and community based organizations on the concept of the "medical home" for clients, within MCH. Existing collaborative relationships, e.g., the Federally Qualified Health Centers and the VI Partners for Healthy Communities assist to increase services to infants, pregnant mothers, mothers and children in both districts. Reaching our populace with the requisite services is a collaborative effort with programs such as Immunization Program who through their mandate welcome improved immunization of all children against vaccine preventable diseases. In addition, linkages with agencies providing services to adolescents are an ongoing activity, e.g., administering comprehensive health behavior survey as many are cooperative and committed to improved health habits for the adolescent population.

Public campaigns are being ensued to improve outcomes through home visiting initiatives, safe sleep practices and heighten the awareness of reducing the burden of illness due to obesity in children and adults on all three islands. MCH Program Priorities are inter-linked in the department's community education and outreach campaign; and, they include client counseling on health behaviors linked to obesity and other chronic diseases, exhibitions at Public Health Week and other year round activities on the benefits of a healthy lifestyle geared toward children, youth and families – all intended to further reduce obesity among this population.

Mental Health

Mental health undoubtedly remains an area of concern in the VI. MCH works closely with the Division of Mental Health (MH) and SAMHSA to develop and implement appropriate initiatives to address concerns and inadequacies in service and access for this population. June 2014 the MCH Program partnered with MH, Alcoholism and Drug Dependency Services to convene a Learning Community (LC) for trauma informed care in collaboration with the Complex Trauma Treatment Network (CTTN).

### **Women/Maternal Health**

Results of the 2015 MCH & CHSCN survey indicated that overall, 76% of the women surveyed reported knowing they were pregnant at between one and 13 weeks. About 64% reported having a prenatal visit during the first 13 weeks, and an additional 32% had a visit when they were two to six months pregnant. The majority (93%) also reported receiving prenatal care as early in the pregnancy as they had wanted. More than half received their prenatal care from a health department clinic (54%), 39 percent from a community health center clinic, and eight percent from a doctor's office.

### **Perinatal/Infant Health**

The low birthrate for the USVI is 11.6% representing a rise over past years and higher than the national rate of 8.3%<sup>[1]</sup>. The high overall rate for the USVI may be impacted by the high number of uninsured for the childbearing age-range. In response to the lack of access to care and to improve healthy birth outcomes for infants, the ECAC, with support from the Community Foundation of the Virgin Islands, promotes "text4baby" - a free text messaging service designed to provide pregnant women and mothers of newborns with information about taking care of themselves and their babies. As of July 24, 2014, 831 women were enrolled in the VI. Additionally, the USVI is ranked #1 among all states and territories for the number of women per 1000 estimated pregnancies and births with 86. (*ECAC Strategic Report, 2014*).

### **Child Health**

Three-quarters of parents surveyed in 2015 reported that their children were in excellent or very good health. However, one in three reported at least one medical condition, and more than half had additional medical needs. Both the number reporting a condition and the number that had additional needs increased between 2010 and 2015, but this may be because the children were older in the 2015 sample. Satisfaction with care and care coordination increased between 2010 and 2015. This was true for almost every question that addressed satisfaction with care. Respondents also reported that doctors were providing more of the recommended information.

In general, parents reported their children's general health status was "excellent" or "very good" (77%), and about 53% felt their child's health care needs were not demanding, while 37% felt they were "somewhat" demanding. About one in 6 (17%) indicated that their child used more medical care than other children their age (14 missing), and 17 percent indicated that their child was limited in doing things. More than a third of parents indicated that their child had one or more conditions (37%). The most commonly indicated child health conditions were asthma (12%), eczema or skin allergies (10%), muscle or bone problems (8%), and speech problems (5%)<sup>[2]</sup>. Overall, 55 percent of respondents indicated that their child had a medical need.<sup>[3]</sup> Among parents for children older than 4 years, 18 percent had missed five or more days due to illness in the past month.

MCH & CSHCN continues to partner with community based organizations such as Early Head Start-Lutheran Social Services and PreSchool Education Program-Department of Education to develop and distribute information cards on health, early intervention and relevant services for the early childhood population. These cards list available services and contact numbers and are available at all Head Start and child care centers, clinic sites and various community partners offices throughout the territory.

### **Children with Special Health Care Needs**

Between 2010 and 2015, services increased. More people reported receiving services from the Early Intervention Infants and Toddler Program and Special Educational Services. There was also an increase in the proportion of children who had an IEP. Overall, one in six respondents reported missing or putting off an appointment, primarily because they were unable to get one. However, four out of five children had received a check-up in the past 12 months, and the proportion who had a primary care physician increased.

The program continues to provide medical homes for children with special health care needs. Public health nurses continued to provide care coordination. Interventions included advocacy, education, case management, counseling, and nursing procedures. Services were provided in a variety of locations including in the home, by phone and in other locations such as hospital, clinics or school or child care setting. Program nurses, physicians and allied health staff continued to work with families to make decisions about care and services for children. Meetings and case conferences attended during this period focused on transition from early intervention programs to school; children with special needs in the foster care system; and collaborations between public health nurses and families.

### **Adolescent Health**

Health challenges continue to include obesity due to the combination of poor nutrition with low intake of readily available fruits and vegetables and low level of physical activity, even in many school settings. A large burden of asthma and diabetes are probably related to obesity, but deserve attention because on their own they can cause serious, and expensive, health risks. With respect to health risk behaviors, marijuana and alcohol use are much more concerning than tobacco. Sexual health risks for both STI and pregnancy are a concern because of the reported behaviors and were also recognized as topics that need to be addressed by youth themselves.

Teenage pregnancy and parenthood also continue to be major concerns threatening the development of teens and their children. Teen parents are more likely to lack sufficient developmental maturity and skills to consistently and adequately care for their children. Teen mothers are more likely to be unemployed. Children of teen parents are more likely to have health concerns, have behavior and learning problems, drop out of school before graduating, and become teen parents themselves – in a cycle that repeats the early childbirth risk. The rate of babies born to teens, ages 15 to 19, in the USVI is 43.1 births per thousand births, down from 51.3 births the previous year, representing a total of 164 births and representing 10% of the total live births and compared to 34 per thousand in the nation (*ECAC Strategic Report, 2014*).

The MCH & CSHCN Program continues to advocate for Adolescents access to a basic level of health care. The discussions and strategic planning are focused on how and where to provide confidential, appropriate care for their adolescents. Our contribution to this process is to engage Providers through surveys on the best practices to address the concerns of their adolescent patients and ways to guide their development as independent agents with regard to their health. Service providers will play an integral role in the coordination of the comprehensive services that influence the health behaviors of adolescents. Moreover, providers will understand and facilitate entry to specialized services for those adolescents who require them. For those services that are specialized, mechanisms will exist to assist adolescents to pay for and obtain necessary care from multiple sites and providers.

### **Cross-cutting/Life course**

#### Oral Health

Dental services that were available at clinics administered by the Department of Health were suspended in 2011 and have not resumed. The Federally Qualified Health Centers have been filling the gaps in Dental services and provide examinations, fluoride applications, fillings and extractions to the children and families who have Medicaid and who are underinsured or uninsured. The School Based Preventive Program was discontinued due to the resignation of the dentist at the start of 2010 and the position has not been filled to date.

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[1] *U. S. Virgin Islands Kids Count Data Book 2009.*

[2] Children could have multiple conditions and as a result total may be higher than 100%

[3] A medical need was defined as any current condition; fair or poor health; the use of more medical care; a condition that sometimes, usually, or always effects their ability to do things; or a limit on their ability to do things.

[4] *Results from the 2009 Virgin Islands health Insurance Survey (January 2010).*

## **II. Components of the Application/Annual Report**

### **II.A. Overview of the State**

#### **State Overview**

##### **Political Status**

The US Virgin Islands is an unincorporated territory under the jurisdiction of the President of the United States. Residents are citizens of the United States. Pursuant to the Organic Act of 1936, The USVI is run by an elected Governor, with a non-voting Delegate to Congress, and a fifteen member Legislature. In 2010, a proposed Constitution for the USVI, as drafted by the Fifth Constitutional Convention, was forwarded to the President of the United States for review.

##### **Geography**

The U.S. Virgin Islands (USVI) is comprised of four major islands-St. Croix, St. Thomas, St. John, Water Island, and approximately 50 small, mostly uninhabited islands. The USVI is located in the Caribbean Sea at the eastern end of the Greater Antilles and the northern end of the Lesser Antilles. The Territory is 1,600 miles south southeast of New York; 1,100 miles east southeast of Miami; and 100 miles southeast of San Juan.

Of the many islands and cays comprising the U.S. Virgin Islands, only four are of economic or clinical significance at the present time. The largest, St. Croix, is 82.9 square miles, mostly flat and therefore, the most suitable for intensive industrial and agricultural development. St. Croix has two main towns-Christiansted, the larger of the two on the east, and Frederiksted, the smaller and more depressed on the west.

St. Thomas lying forty miles due north of St. Croix, is a major cruise and tourism destination and differs in both economic and geographic structure. St. Thomas is approximately 32 square miles with rugged mountains that rise sharply from the sea to heights of up to 1,500 square feet. The population density is 1,543.8 persons per square mile, more than twice that of St. Croix. Charlotte Amalie, the Territory's capital, is located on the south east quadrant of St. Thomas.

St. John lies approximately four miles east of St. Thomas, with picturesque hills and pristine waters. More than half of the island is designated as a National Park through the United States National Park Service, which has served to preserve much of this island's natural beauty. St. John is only accessible by boat; the main town Cruz Bay is centrally located.

The fourth isle is Water Island, transferred from the Department of Interior on December 12, 1996. The size of the island is 2-1/2 miles long and 2 miles wide with an area of 500 acres. Water Island is separated from St. Thomas by 2 miles and is close enough to draw life support from.

#### **A. Demographics**

##### **Population**

According to the 2010 United States Census, the USVI population consisted of 106,405 persons; 50,601 on

St. Croix and 51,634 on St. Thomas and 4,170 people living on St. John. This corresponded to a 2% decrease from the 2000 U.S. Census population of 108,612 (Chart 1). The 2010 US Census estimated that Males represented 48% (50,867) of the population with females at 52% (55,538) (Chart 2).

### **Population less than 19 years**

In 2010, children represented 25.4%% of the population, down from 35% in 1990 and from 32% in 2000 and similar to the nation which was 24%. Over the past ten years the per cent of children as compared to the total population has declined. 52% of the children of the VI live on St. Croix, 45% on St. Thomas, and 2% live on St. John.

The VI population decreased 6% overall during the period 2000-2010 (101,809 to 106,405), with significant decreases evident in the 0 – 5 (12%) and 5-19 (16%) age groups. Conversely, during this period, the 20- 59 and 60+ age groups showed increases of 3% and 56% respectively.

Regarding the number of children birth to five years, the VI Department of Health, Division of Vital Statistics and Research, indicated that there were 7,978 births between 2009 (1,753 births) and 2013 (1,320 births). This number does not account for children moving into the territory or moving off-island. These figures reflect a decline over the last five years by more than 400 births from 2009 to 2013. The general consensus is that many have moved off-island for economic reasons and better employment opportunities, impacting the birth rate since the economic downturn in the USVI, particularly on St. Croix.

**Table 1: Population less than 19 years** (see appendix)

### **Race and Ethnicity**

The USVI population primarily consists of persons who are predominantly of African descent, i.e., Black, West Indian or African-American. The district of St. Thomas/St. John holds the highest percentage of people of African descent, while St. Croix holds the highest percentage of Hispanics, whose place of origin is more often nearby Spanish-speaking islands, such as Puerto Rico or the Dominican Republic. The 2010 Census estimated the racial composition of the V.I. population as Black/African American 76%, Whites 16%, and Other races 8% (Table 5).

**Table 2: Population by Race**

## **Population by Hispanic or Latino Origin (See Appendix)**

The 2010 Census estimated 18,504 persons of Hispanic origin. Demographics for this population showed a decrease among Puerto Rican and Other Latino/Hispanics, while there was an increase among Dominican residents.

### **Table 3: Population by Hispanic/Latino origin (See Appendix)**

## **Languages Spoken in the Home (See Appendix)**

According to 2010 Census results, the graph to the left indicates the languages spoken in the homes of families in the Virgin Islands. Two-thirds, or 64.9% speak English only. Of the households in which Spanish or Spanish Creole is spoken, approximately 75% of those have at least one person 14 years of age or older who speaks English or speaks English well. Of the households in which French or French Creole is spoken, approximately 80% of those have at least one person 14 years of age or older who speaks English or speaks English well. Approximately 6.67% (or 2,886) of all households do not have a person over age 14 who speaks English only or English very well.

## **Population by Nativity / Citizenship**

The Virgin Islands is a diverse and multicultural society. The 2010 Census estimated that approximately 66.2% of the population was comprised of people born in the VI. This is a noted increase from the 2000 US Census which estimated that 62% of the population was born in the V.I. and 37 % born outside of the territory at that time. The 2010 Census further notes that 21% (28,199) of the population are naturalized citizens, 32% are born outside of the territory and 12% are not US citizens. Many of the persons who migrated to the territory seeking employment establish citizenship here.

### **Table 4: Population by Nativity/Citizenship (See Appendix)**

## **B. Economic Indicators**

### **Median Income**

In 2010, the per capita income of households in the Virgin Islands was reported as \$21,367, equivalent to about half (53%) of the average per capita income of households in the U.S. St. John had the highest per capita income of \$26,326, followed by St. Thomas at \$16,260 and St. Croix at \$16,083. The median income for the VI in 2010 was \$45,058 while up from the previous year (\$43,691) it still lags far behind the national family median income of \$61,544.

### **Table 5: Per Capita and Median Income (See Appendix)**

### **Cost of Living Indicators**

VI family median income 2010 was \$45,058. This compares unfavorably to the national US family median

income for 2010 of \$61,544. Thus on average, VI families have over \$16,000 less per year to meet their regular expenses than do their stateside counterparts. The per capita income was \$21,362 in 2010 (up from \$17,860 in 2009) and considerably less than the national rate of \$39,937 (USVI Kids Count Data Book 2012). The cost of living in the USVI is higher than in most jurisdictions as indicated by the fact that federal workers living in the USVI receive a cost of living adjustment to their salaries of 22.5%. Therefore, the difference in income is felt even more, as money doesn't buy as much, putting greater stress on families.

Studies have shown that the cost of living in the Territory is about 30% higher than Washington, D.C., the place with which the Territory is usually compared. A common indicator of this is the 25% Cost of Living Allowance (COLA) that Federal government employees working and living in the VI receive to supplement their salary due to the high cost of living. The inflation rate in the Virgin Islands is currently about 4.0%. The consumer price index (CPI) which is used as a measure of inflation has significantly increased in the VI from 14.2% in 2005, to 17.6% in 2006, and 23.3% in 2007 to 32.1% in 2008. According to the most recent survey by the VI Bureau of Economic Research the annual percent change for the consumer price index is approximately 7.1% each year compared to 3.8% nationwide.

### **Poverty Status**

Poverty rates in the Virgin Islands are extraordinarily high compared to rates in the US. In 2010, the number of children living in poverty increased to 30.3% as compared to 20% nationally; 21% of VI families continue to live in poverty. The percentage of VI families with children living below the poverty level increased to 31% in 2009 as compared to 24.9% of families in 2009. Of the VI families with children living in poverty, 74.7% were headed by single mothers. [1] The number of children living in poverty continues to rise in the VI with 35% of children living in poverty on St. Croix, 26% on St. Thomas and 17% on St. John.

The federal poverty threshold for 2010 was set at \$22,050 for a family of four (HHS Poverty Guidelines, August, 2010). In 2010, according to our most recent Kids Count, 31% of families with children were living in poverty, with 30.3% of all children living in poverty, and 34.6% of children under five years living in poverty; as compared with 22% of the nation's children living in poverty. St. Croix children had the highest child poverty rate with 35.3% (USVI Kids Count Data Book 2012). It should be noted that this information does not reflect the impact of Hovensa's closing, as it was collected prior to 2012. Although local and regional variations are not reflected in the federal poverty thresholds, by implication with the higher cost of living in the USVI than in most jurisdictions, the actual poverty level in the USVI is likely significantly higher than reported.

When considering the economic status of children and families in the USVI, one cannot ignore the impact of economic conditions on the general community as described above. Our most recent statistics are generally from the 2010 census; therefore, they do not fully reflect the impact of the above negative economic circumstances. Wherever more recent information has been available, it is noted.

### **C. Community Economic Factors**

The economic situation in the territory has worsened over the last five years as a result of the recession; the exodus of businesses which had EDC (Economic Development Corporations) benefits; and the closure of Hovensa Oil Refinery, the largest private employer with no significant relief. St. Croix's economy is primarily based on manufacturing. Major industries have historically include Hovensa Oil Corporation, V.I. Rum Industries, watch factories and several pharmaceutical companies. St. Thomas' economy is largely based on tourism and the retail industry. In 2010 the U.S. Virgin Islands economy remained in the throes of a recession, with virtually all sectors of the local economy being impacted by the US and global recession. Declines were seen in employment, visitor arrivals, building permits and government general fund tax revenues as effects of the widespread economic recession continued to be felt from the first to the fourth quarter of the 2009 fiscal year.

Employment losses spread across most industries with a net loss of 1,069 in non-agricultural employment. In 2010,

the territory's unemployment rate reached 9.6% in St. Thomas/St. John and 11.7% on St. Croix. the highest rate since April 2001. The jobless rate averaged 7.1% for 2009, up from 5.8% in 2008. Unemployment insurance claims remain above historic levels although they have moderated from the peak of 607 in September 2008. An increase in the unemployment rate is expected through the first quarter of the 2010 fiscal year.

The number of workers filing for unemployment benefits has risen above historic levels. The rising unemployment rate and the sharp increase in initial claims substantiate that the recession has yet to bottom out and recovery is still some ways away. The economic situation for the territory has worsened over the last two years as a result of the recession; the exodus of businesses which had EDC (Economic Development Corporations) benefits; and the closure of Hovensa Oil Refinery, the largest private employer.

Economic Development Corporations (EDC's) have been a major economic factor in the VI economy. This name stems from the almost 90% tax benefits provided by the local government's Economic Development Authority. There are approximately 94 EDCs in the territory, below the 109 of just three years ago and way below the peak prior to 2007. Changes in the IRS Code in 2007 tightened residency requirements for EDC applicants while other changes made it more difficult for recipients to demonstrate "VI source income" and increased the chances of audits. This resulted in a decrease in the number of new applications and the exodus of many EDC companies who felt the new requirements made it too difficult to operate in the VI and qualify for the preferential tax treatment. The impact has been strong. Along with the loss of highly paid employment, the government has seen a loss of \$50 million dollars annually in taxes paid by several major EDC companies.

In January, 2012, the Hovensa Oil Refinery on St Croix announced their intent to close the refinery and operate only an oil storage facility. 2,150 employees and sub-contractors were dismissed in April 2012 and only a small work force of approximately 350 persons were retained. This represented an annual payroll loss between \$269 million and \$301 million dollars. Their plans are to dismiss most remaining workers in July and September retaining only 100 long-term staff to operate the oil storage terminal. To put this in perspective, the April dismissals represent a loss of 27% of the average private sector gross pay on St Croix. The manufacturing sector counts for 20% of the VI economy and Hovensa represents more than 50% of the manufacturing sector.

The impact on government revenue was dire. Tax collections from Hovensa peaked in 2007 and declined considerably by 2009, when the refinery began experiencing annual losses. The expected impact on VI Government revenue for FY2013 was \$92 million dollars. Of this, \$69 million reflect the reduction in payroll taxes; \$30 million in corporate taxes and fees and \$23 million is estimated as the tax loss due to the ripple effect the closing will have on other businesses. The economic impact on St Croix is expected to be harsh. In 2011, Hovensa's total economic activity in the VI was \$420 million of which \$346 million was in payments to individuals and vendors, the vast majority spent on St. Croix. Losing this amount of spending on a small island will undoubtedly have a large impact on all businesses including landlords, retailers, restaurants, bars, private schools, and so forth.

St. Croix's unemployment increased from 9% when the closure was announced to 17% by December 2012. It is estimated that 30% of the employees migrated off-island to seek employment elsewhere. 1,300 of those laid off received unemployment compensation.<sup>37</sup> The impact on government revenue has been dire. Tax collections from Hovensa peaked in 2007 and declined considerably by 2009, when the refinery began experiencing annual losses. The Director of the VI Bureau of Economic Research was quoted as estimating the total tax revenue loss as \$140 million from the closing of the refinery reflected in the reduction in payroll taxes, corporate taxes and fees, and the tax loss due to the ripple effect the closing had on other businesses.

Hovensa had been generous in supporting many schools and non-profits and providing scholarships. In 2010, the

company made over \$450,000 in donations to community organizations plus over \$4.5 million in tuition assistance.

With the loss of this assistance, one private school closed and the two largest merged cut teaching staff and expenses in order to stay operational. Additionally, the company was generous in other ways: staff contributed their own money, participated in charity fundraisers, and served as board members; and the company provided free expertise and donated equipment. A concern shared by government and non-profits is that at a time when the non-profit sector is needed more than ever to assist in alleviating social problems, it may be financially less able to do so.

The Virgin Islands Government has historically been thought of as a source of steady, secure employment with fairly regular pay raises. This has changed. The Government experienced a 37% decrease in core revenues in 2009 as the recession took hold. ARRA funding and borrowing helped fund Government services through 2010. Most Government departments have experienced budget cuts each of the last three years, with pay and hiring freezes. During the summer of 2011, every Government worker earning over \$26,000 a year was given an 8% pay cut which remains in effect. At the same time, an early retirement incentive was put in place. Beginning in January, 2012, the Government had its first ever employee dismissals for economic reasons as all departments were required to further reduce their budgets mostly through staff reductions. Overall, Government employment was down about 1,000 employees since 2007 to under 8,000 before the recent dismissals. Staff who have retired or resigned have largely not been replaced unless their salary comes from federal funds or the position is necessary to continue to receive federal funds. In 2014, the Governor has requested Legislative approval of a loan to help fund government services at the current level.

There is also some positive economic news in the private sector. The territory is in the midst of a “middle mile” broadband initiative to make the vast internet capacity of the international AT&T and Global Crossings undersea fiber optic cables widely available throughout the territory. These cables connect Africa and South America to the United States have connections through the VI, but the VI has never had the infrastructure to utilize them. This project will allow for internet-based companies to move to the territory and for Virgin Islanders to establish internet-based businesses. There will be opportunities for employment in this growing industry. Diageo, Inc. recently completed construction of a distillery on St Croix to produce Captain Morgan rum. Captain Morgan is the number two best selling rum in the US and is growing at an annual rate of 9.5% according to a study done for the Governor by Fiscal Strategies Group, Inc. Fortune Brand company also recently completed agreements and environmental upgrades that will lead to an increase in production of the highly regarded Cruzan Rum already produced on St Croix.

Tourism numbers are climbing again according to a report in the VI Daily News. Overall, 2.6 million people visited the VI in 2011 a 5.4% increase compared to the 2.5 million visitors in 2010. This is reflected in the rebound in annual cruise ship passenger arrivals that began in 2010 after numbers had dropped in the midst of the recession. Two million people came on cruise ships with cruise arrivals up 2.6% to 698. Of note, over 100 cruise ships called on St Croix where a few years ago only a couple of dozen ships came into St. Croix.

### **Mass Transit System**

The Virgin Islands Transit System (VITRAN), under the auspices of the Department of Public Works, Office of Transportation, is responsible for coordinating and providing public transportation to residents of the Virgin Islands. VITRAN provides transportation between remote locales, the main towns, and along the major thoroughfares. Buses are equipped and available to provide transportation for individuals with disabilities who require use of wheelchairs or other assistive devices. Major cutbacks in the scheduling and operation of these buses limits the service available to the public. Private taxi services are frequently utilized as the primary mode of transportation. VITRAN-PLUS Para transit Services (VITRAN-PLUS) provides public transportation to certified disabled persons, in accordance with the Americans with Disabilities Act.

## Environment

A unique factor, which affects the territory's infrastructure, is the threat of tropical depressions and / or named storms/hurricanes. While there have been no major storms in the past three years, the territory and its residents continue to experience the economic impact of high insurance rates. In addition, delays in service and systems begin from the moment hurricane warnings are issued. The community is encouraged to begin hurricane preparedness from the start of the hurricane season. Service disruptions in all sectors of the community can last from one day to weeks or months depending upon the severity of the storm and its destruction of utilities and buildings, when and if it makes land fall.

## Socioeconomic Factors

The total number of individuals receiving SNAP (formerly Food Stamps) benefits at any point in FY 2013 was 34,154 within 15,527 households, which breaks down to 15,023 recipients on STT/J and 19,131 on STX. This represents an increase of almost 2000 recipients from 2012. It should be noted that 32% of households that receive SNAP, excluding those headed by seniors, have employed adults in the home.

The TANF program replaced the predecessor Aid to Families with Dependent Children (AFDC) program as part of the welfare reform legislation of 1996. It was further changed in 2005 and 2009 and in particular added a focus on strengthening families through HHS Poverty Guidelines (August, 2010). U. S. Virgin Islands Kids Count Data Book 2012. Testimony presented to the VI Legislature on April 18, 2013 by Commissioner Chris Finch, Department of Human Services. Information from the VI Department of Human Services Total Annual Aid \$92,542,596 Food \$57,210,062 Cash \$3,682,534 Medical \$30,000,000 Energy \$1,650,000 Financial Benefits 2013 22 promoting marriage and responsible fatherhood. It is a block grant program to help move recipients into work and off welfare. The four purposes of TANF are:

- 1) assisting needy families so that children can be cared for in their own homes;
- 2) reducing the dependency of needy families by promoting job preparation, work and marriage;
- 3) preventing out of wedlock pregnancies; and
- 4) encouraging the formation and maintenance of two-parent families.

An individual adult may receive TANF benefits for only 5 years (60 months) during one's lifetime. With few exceptions, individuals on TANF have a work participation requirement which may include subsidized work, community service, and job training and education.

TANF provides cash assistance to single parents with dependents based primarily on asset and income tests. In the Virgin Islands, the head of household receives \$180 a month plus \$80 for each qualifying dependent. The table below shows the TANF statistics for 2013. These numbers may be surprisingly low to some, as there is a perception about the large number of persons receiving welfare assistance. The reality is 1,854 people received TANF benefits, 496 of these were adults and 1,358 children. The total TANF expenditure for 2013 was \$1,606,190 (ECAC Strategic Report 2014).

**Table 6: TANF Statistics for FY2013** (See Appendix)

## Children in Families

Children's well-being is significantly tied to family structure. Research indicates that children do best when raised by their biological mother and father in a low-conflict marriage. Even after controlling for family socioeconomic status,

race/ethnicity, and other background characteristics, studies show that children in never-married, single-parent, or divorced families face higher risks of poor outcomes. While many children in single parent families grow up without problems, children of single mothers are generally more likely to be poor, have multiple living arrangements, have a negative relationship with a biological parent, receive lower levels of parental supervision, have lower educational attainment, and lower employment prospects.<sup>54</sup> Of all USVI families living in poverty, 74.7% were headed by single mothers and of all the single mother families with children, almost half (47.8%) lived in poverty. In the VI, 47% of children live in households headed by a single parent (ECAC Strategic Report 2014).

### **Health Insurance**

Economic changes have led to changes in health care insurance coverage. A 2012 study revealed a major drop in employer group insurance and an increase in coverage through public programs, i.e., Medicaid and Medicare. The number of uninsured increased from 28.7% to 29.7%, with 18.8% of children birth to five years uninsured. The local structure of the State Children's Health Insurance Program (SCHIP) did not insure any additional children. Individuals in the prime parenting age-group are uninsured at the rate of 39.4% of 18 to 24 year olds and 45.4% of 25 to 34 year olds. Any efforts to address elimination of health disparities in this population are severely hampered by stringent eligibility criteria of the local Medicaid Program (ECAC Strategic Report 2014).

There are three important differences between the territorial Medicaid program, called Medical Assistance Program (MAP), and state programs. First, the federal funding available to the territories is capped at a set amount. There is no cap for the states. Under the Affordable Care Act (ACA), the VI cap has been raised to a point that it is no longer the limiting factor it traditionally was. Second, the states matching requirement is determined by their per capita income. For the territories, the matching requirement is set by statute. The FMAP, which is the share of a state's Medicaid costs paid by the federal government, ranges from 50% for the higher income states to 74% for the lower income states. The territories' FMAP rate is 55%. An example serves to show the difference. If the Virgin Islands spends \$10 million of its own money on Medicaid services, the federal government, at 55% FMAP, will put in \$12.2 million. If instead, we received the FMAP of 74% our per capita income would allow, then, if the VI put in \$10 million, the federal government would put in \$28.5 million, an increase of \$16.3 million without the VI spending any additional money. Finally, third, it is important to realize as the Affordable Care Act is implemented, many of the Medicaid enhancements contained therein are not available to the territories (ECAC Strategic Report 2014).

MAP in the VI provides medical assistance based on income and asset tests to individuals and families that are medically and categorically eligible. Categorically eligible clients are the clients of TANF, AABD, and foster children. Medicaid is undergoing several expansions. Prior to expansion, medically needy eligible clients were those in households that earned no more than \$5,500/yr for the head of household plus \$1,000 for each additional qualifying member. Thus a family of four could earn up to \$8,500/yr and qualify for MAP. As of October, 2012 there were 9,354 recipients. Funds are insufficient to provide services for all Medicaid eligible children and families. It provide an accurate estimate of the number of children who received services paid by Medicaid funds. Medicaid is accepted at the government run health facilities. There are a limited number of private providers that accept Medicaid as a form of payment. This presents a unique challenge in reducing health disparities

### **In-migration**

Due to the geographic proximity to British possessions of Tortola, British Virgin Islands, and the island of Hispaniola-Santo Domingo and Haiti, in-migration of undocumented residents from neighboring Caribbean islands regularly occurs. Immigrants come to deliver their babies in the Virgin Islands in order to ensure U.S. citizenship for their offspring. They are uninsured and ineligible for any formal government programs. Most of the pregnant women present without records of prenatal care. In complicated pregnancies, critical newborns are cared for at the expense

of the local hospitals and ultimately the Government of the Virgin Islands. Language differences present a challenge for effective communication and greater cultural competency is a developing need. Actual numbers for undocumented residents are unavailable and estimates vary due to lack of data from reliable and knowledgeable sources. Additionally, this population is considered itinerant and constantly changing. They generally live in certain geographic areas, are non-English speaking, and access the health care system only when necessary.

## Health Infrastructure

The three main facilities for primary care services are MCH & CSHCN Clinics, PHS 330-Community Health Centers, and hospital-based Community Health Clinics. On St. Thomas MCH's principal facility is located in the western district, the Community Health Clinics at the Roy L. Schneider Hospital serve the mid-island district, and the East End Health Center is located in the east district. On St. Croix, the Frederiksted Health Center is located in the western end of the island, and the MCH & CSHCN principal facility is located in the east at Charles Harwood Complex. On Cruz Bay, St. John, the Morris De Castro Clinic is the site for the MCH & CSHCN monthly Infant/Pediatric high-risk clinic.<sup>[6]</sup>

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<sup>[1]</sup> USVI Kids Count Data Book 2011

44 USVI Children in Poverty

<sup>[2]</sup> Interview with Hovensa officials

<sup>[3]</sup> Report from the Governor's Financial Team

<sup>[4]</sup> Ibid.

<sup>[5]</sup> Interview with Hovensa officials

<sup>[6]</sup> Title V Block Grant Annual Report 2009

## **II.B. Five Year Needs Assessment Summary**

### **II.B.1. Process**

#### **Needs Assessment Summary**

##### Introduction

As a recipient of the federal Title V Maternal and Child Health Block Grant, the United States Virgin Islands (USVI) is required to complete a statewide needs assessment every five years to evaluate and assess the relevancy and adequacy of Maternal and Child Health (MCH) Services. The USVI Title V Five Year Needs Assessment is the first step in a cycle for continuous improvement of maternal, child and adolescent health.

The Maternal and Child Health & Children With Special Health Care Needs Program (MCH & CSHCN), VI Department of Public Health has prepared the following Needs Assessment that identifies the need for: preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children and adolescents with special health care needs that are consistent with health status goals and National MCH priority areas as reflected in the Title V program's National performance and outcome measures.

The needs assessment for the 2015 to 2020 cycle resulted in the identification of priorities for the maternal, child, and adolescent health population over the next five years. During this five year period, actions and strategies will be implemented, results will be monitored and evaluated to determine the success of efforts in addressing these priorities, and adjustments will be made as necessary to continue to enhance the health of USVI women, children and adolescents.

#### **I. Process for Conducting the Needs Assessment**

The guidelines as stated in OMB No: 0915-0172, the Title V Maternal and Child Health Services Block Grant to State Program; Guidance and Forms for the Title V Application/Annual Report and the accompanying Appendix of Supporting documents were used to guide the process of conducting this needs assessment. The specified guidelines included: describing the goals, framework and methodology guiding the Needs Assessment process; 2) the level and extent of stakeholder involvement; 3) quantitative and qualitative methods used to assess strength and needs; 4) data sources used; 5) interface between the collection of the Needs Assessment data, finalization of state's Title V Priority Needs and development of Action plan.

#### **Goals and Vision**

The mission of the 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 endeavors 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.

#### **Goals & Objectives:**

MCH & CSHCN Program goals are to:

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 preconceptual health, utilization of appropriate services; assuring early entry into prenatal care, and improving perinatal care.

### **Leadership**

Title V needs assessment efforts were led by MCH & CSHCN Administrative staff. MCH & CSHCN coordinated and supported a Planning committee, which met several times during this collaborative process. Our dedicated partners from the Department of Human Services, the Department of Education, Virgin Islands Perinatal, Inc., the Early Childhood Advisory Committee, and the Interisland Coalition for Change and other community-based organizations were integral in this needs assessment process.

### **Methodology**

The Title V Program in the Virgin Islands serves the entire population and provides services on all three major islands of St. Croix, St. Thomas and St. John. The Title V Five-Year Needs Assessment, involved a review of primary and secondary sources of data for all three major islands, provided critical elements that facilitated the classification and identification of Priority Needs for the Territory. The MCH & CSHCN Program also coordinated with other appropriate needs assessments that have been conducted by supporting agencies to include: the most recent community assessments from Head Start and Early Head Start; the recent needs assessment from the Early Childhood Advisory Council; current community-based and prevention-focused programs to prevent child abuse & neglect; and other family resource services.

### **Stakeholder involvement in the Needs Assessment.**

Stakeholders such as members of the Early Childhood Advisory Strengthening Families Workgroup, Office of Child Care, Virgin Islands Perinatal, Inc. and the Early Childhood Comprehensive Systems program assisted in this process, particularly in the review of existing programs, identifying gaps in service and evaluating the capacity of existing home visiting programs in adequately addressing the needs of our MCH population. All forms of stakeholder input were considered in the priority-setting process.

### **Methods for Assessing At Priority Needs**

Community, as referred to in this needs assessment, apply to those for which data and/or other information are most available and that which best represent the make-up of the State. Geographically, the community based information that was available is used to describe the Territory according to its districts of St. Croix and St. Thomas/St. John. With a combined population of just over one hundred thousand, with similar demographics, socioeconomic variables, issues of access and availability, similar types of services, health status and population indicators, Territorial information is used to represent the general makeup of the USVI. Through an engaging process of discussion among stakeholders and service providers throughout the Territory, members were able to determine areas in most need.

## **Methods for Assessing State Capacity**

Both quantitative and qualitative methods were used to assess the needs of the MCH population and strengths of the existing services in meeting those needs. Data gathering, review and analysis was completed using the MCH needs assessment planning team, bureau staff, and a consultant. The MCH planning team looked at the current state of preventive and primary care services by reviewing available secondary data from several reliable sources both national and local. Team members identified major priorities to focus on which included: the collection and analysis of secondary data; identifying and describing the current capacity, needs and gaps in the infrastructure of existing preventive and primary care services; and what would be necessary to support and sustain a comprehensive system of care for children with special health care needs. MCH planning team meetings aimed to: review the strategies and desired outcomes for the needs assessment process; assess the effectiveness of needs assessment process to date; and increase understanding of the role of the needs assessment in addressing the population health domains and identifying MCH priority areas.

### **Data Gathering**

In order to identify the specific priority areas of the MCH population, Title V indicators and measures, and other quantitative and qualitative data gathered from across the territory were used. The MCH Program coordinated with other appropriate needs and community assessments that were conducted by supporting agencies to include:

- Most recent needs assessment
- Community-wide strategic planning and needs assessments
- Inventory of current unmet needs
- Other family resource services in the community

### **Data Sources**

Data considered in this needs assessment was obtained from Title V, Head Start, Early Head Start, the Office of Intake and Emergency Services- Department of Human Services, the Early Childhood Advisory Committee Strategic Report, the Department of Education and other data sources. The same data sources used for Title V reporting were also used for indicators of premature birth, low-birth-weight infants, infant mortality, poverty, and school drop-out rates. Neither CAPTA nor SAMHSA provide state-wide data on the indicators. Information on unemployment was obtained from the Department of Labor, while economic data was gathered from the VI Bureau of Economic Research.

### **Community Needs Assessments.**

Various community needs assessments were gathered and analyzed from several collaborative partners in this process. Assessments reviewed included those previously conducted and completed by collaborative partners, including Early Head Start- Lutheran Social Services, Head Start and the Early Childhood Advisory Committee. These community assessments touched on a variety of issues in the MCH populations that these respective agencies currently serve and expounded the process by adding a comprehensive look at the current need and capacity of existing preventive services in the Territory.

### **Title V Five Year Needs Assessment**

The Maternal and Child Health & Children With Special Health Care Needs Program (MCH & CSHCN), Title V Five Year Needs Assessment surveys served as a fundamental data source for the identification and analysis of current needs, capacity and health status indicators for the maternal and child populations based on: preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children and adolescents with special health care needs that are consistent with health status goals and National health objectives and performance measures.

## **Linkages between Assessment, Capacity and Priorities**

Areas of need, identified through discussions with stakeholders, included current agency capacity issues, health status and data issues, and the required approaches or strategies to structure and support a more comprehensive health care system. Several areas of need were relevant and noted to be important throughout the community-poverty, high rates of uninsured, domestic violence; this highlighted the importance defining and addressing issues of capacity. The final priorities were selected while taking into consideration: 1) progress that can be tracked and measured, 2) opportunities for collaboration, 3) redirection or leveraging of resources, 4) sustainable or longitudinal efforts, 5) goal-oriented efforts, 6) barriers to effectiveness, and 7) cost.

### **Dissemination**

Before finalizing, the Needs Assessment document will be distributed to internal stakeholders for comment, editing, and to ensure that the assessment captured all aspects of the work and findings of the needs assessment. The drafted assessment document will also be reviewed by external stakeholders that attended the stakeholder input meeting and participants in the key informant process. The draft document will be made available for a period of public comment, and input was addressed and incorporated into the Needs Assessment document where appropriate. Once the Needs Assessment document has been finalized and submitted, the complete version will be disseminated to stakeholders.

### **Strengths and Weaknesses of Process**

*Data collection limitations:* Collection of data required to satisfy Title V reporting requirements continues to present a major challenge in this process. There is a lack of or limited availability of data for services provided to the identified population groups in “at-risk” communities. Data collection of service utilization, health practices of the target population and related information needed for effective monitoring of the program productivity, is limited to manual methods. Improvements in data collection will allow the program to better measure critical MCH indicators to support better planning in the future.

*Effective Collaborative Partnerships:* The needs assessment process was strengthened through the partnerships and collaborative efforts that were involved in facilitation of the process. These partnerships underscore the collaborative agreements and community partnerships that further the structuring and development of the Territory’s existing programs. These efforts were beneficial in maximizing efficient use of resources and compiling data on existing programs. This process was also beneficial towards the inception of the development of a comprehensive system for MCH programs (to include home visiting) with MCH staff, other public and private agencies, as well as community stakeholders.

## **II. Findings**

This section presents a summary of the health status of the MCH population relative to the VI’s noted MCH strengths/needs and the identified national MCH priority areas organized by each of the six health population health domains; 2) a summary of the adequacy and limitations of the Title V Program capacity 3) partnerships building efforts relative to addressing the identified MCH population groups and program needs; 4) an overview of the health status of the VI’s MCH population in the following domains: a) Women/Maternal Health, b) Perinatal/Infant Health, c) Child Health, d) CSHCN, e) Adolescent Health, f) Cross-cutting or Life Course; APreventive and primary care services for pregnant women, mothers, and infants up to age one; b) Preventive and primary care services for children; and c) Services for children special health care needs.

### **Women/Maternal Health**

Results of the 2015 MCH & CHSCN survey indicated that overall, 76% of the respondents reported knowing they were pregnant at between one and 13 weeks. About 64% of all respondents reported having a prenatal visit during the first 13 weeks, and an additional 32% had a visit when they were two to six months pregnant. The majority (93%) also reported receiving prenatal care as early in the pregnancy as they had wanted. More than half received their prenatal care from a health department clinic (54%), 39 percent from a community health center clinic, and eight

percent from a doctor's office.

All respondents reported that health care workers talked to them about good nutrition and taking vitamins during pregnancy, and 93% of the respondents reported that the health professionals talked to them about target weight-gain in pregnancy. About half of the respondents were told by their health care provider about body mass index (48%). Three out of five (62%) reported being tested for diabetes; of those, 88 percent reported that the test results were explained to them.

Most reported that their prenatal care included breastfeeding discussion (78%) and a PAP screen (88%). The majority of prenatal care also included a discussion of smoking (89%), illegal drugs (86%), depression (64%), and domestic violence support (58%, excluding 8 missing cases). Three quarters were educated about preterm labor (78%), and 71% reported that they knew what to do if they experienced preterm labor.

Overall, 89 percent of respondents reported taking prenatal vitamins, including 63% who took them every day. Three-quarters had their vaccines updated before their pregnancy. About 92% of the respondents did not visit a dental hygienist before or during their pregnancy. However, 30% had their teeth cleaned less than two years ago. Nearly three quarters stayed within targeted weight gain (74%).

About eight percent of the respondents reported that they had prediabetes or gestational diabetes. Thirty-nine percent of the respondents had an STD, urinary tract infection, or vaginal infection. Of those reporting one or more of these conditions, most indicated that they had yeast infections (22%) or urinary tract infections (11%). Respondents could report having more than one condition and, as a result, percentages may total more than 100%.

Most respondents (92%) reported not experiencing any preterm labor.

### **Perinatal/Infant Health**

Birth weight is an important indicator of infant health. Low birth weight babies account for more than half of all costs incurred to newborns. Low-birth weight babies surviving infancy have an increased likelihood of cognitive and developmental delays. They experience greater health risks and disabilities during their childhood and adolescence and face higher adult health risks. The low birth weight rate for the USVI for 2013 was 10.5% up from the rate of 8.5% in 2010. St. Croix has a higher rate of 12.7% compared to St. Thomas of 8.5%, perhaps due to the higher poverty rate. 86.5% of mothers had a normal birth weight, 13.5% had a birth outcome categorized as low birth weight. 44.4% had an educational level of 9-11 years, 80% had an income of less than \$10,000. 45% of the high risk pregnant clients were without insurance. Despite targeted outreach, 73.5% entered into prenatal care in the second or third trimester (*ECAC Strategic Report, 2014*).

The low birthrate for the USVI is 11.6% representing a rise over past years and higher than the national rate of 8.3% [1]. The high overall rate for the USVI may be impacted by the high number of uninsured for the childbearing age-range. In response to the lack of access to care and to improve healthy birth outcomes for infants, the ECAC, with support from the Community Foundation of the Virgin Islands, promotes "text4baby" - a free text messaging service designed to provide pregnant women and mothers of newborns with information about taking care of themselves and their babies. As of July 24, 2014, 831 women were enrolled in the VI. Additionally, the USVI is ranked #1 among all states and territories for the number of women per 1000 estimated pregnancies and births with 86. (*ECAC Strategic Report, 2014*).

### **Child Health**

#### 2015 Survey Results

Almost two-thirds of the children received no non-parental care (66%). One in five received non-relative care (21%), mainly center-based care. One in four received relative care (24%), primarily at their own home. Very few reported that their child's health made it difficult to find care for them (5%).

Respondents were asked how often they read to the child. About half read to the child daily (49%), and another 14%

read to the child four to six times a week (excluding 19 missing). Among children younger than age 9, 48% of respondents reported that they were read to daily, and another 15% were read to 4 to 6 times a week. Parents were also asked about the child's television watching habits. Watching for two to four hours per day was the most commonly reported response (79%) among the respondents.

Notable differences from the previous survey: In 2010, respondents read to their children less often. Among those younger than nine years, 38% were read to daily, and another 8% were read to 4 to 6 days.

## **Children with Special Health Care Needs**

### 2015 Survey Results

The results of the MCH & CHSCN 2015 survey indicated that about one in seven of respondents (14%) reported they needed someone to help with coordinating their child's care. Nearly one in three (29%) reported that a service provider helped them to coordinate care at least once, mostly from a clinic or health center. When respondents needed information from their healthcare provider, 55% reported they usually or always received the information they needed. Three-quarters were usually or always satisfied with coordination help that they received (73%). When asked how often the respondents thought the doctors and other health care providers spoke with each other about the child's care, across the islands 36% reported "usually" or "always."

Most respondents had heard of the Maternal Child Health Program (87%) while about half reported that their child received help from it (49%).

Notable differences in previous survey: In 2010, although the proportion reporting help with coordinating care was similar, a smaller proportion reported being usually or always satisfied with the help that they received (63%, compared with 73% in 2015). Fewer respondents in 2010 had heard of the Maternal Child Health Program (71%).

## **Adolescent Health**

Health challenges continue to include obesity due to the combination of poor nutrition with low intake of readily available fruits and vegetables and low level of physical activity, even in many school settings. A large burden of asthma and diabetes are probably related to obesity, but deserve attention because on their own they can cause serious, and expensive, health risks. With respect to health risk behaviors, marijuana and alcohol use are much more concerning than tobacco. Sexual health risks for both STI and pregnancy are a concern because of the reported behaviors and were also recognized as topics that need to be addressed by youth themselves.

Teenage pregnancy and parenthood also continue to be major concerns threatening the development of teens and their children. Teen parents are more likely to lack sufficient developmental maturity and skills to consistently and adequately care for their children. Teen mothers are more likely to be unemployed. Children of teen parents are more likely to have health concerns, have behavior and learning problems, drop out of school before graduating, and become teen parents themselves – in a cycle that repeats the early childbirth risk. The rate of babies born to teens, ages 15 to 19, in the USVI is 43.1 births per thousand births, down from 51.3 births the previous year, representing a total of 164 births and representing 10% of the total live births and compared to 34 per thousand in the nation (*ECAC Strategic Report, 2014*).

In 2010, the Youth Risk Behavioral Survey was conducted in the St. Thomas/St. John District Public School District on behalf of the Virgin Islands Department of Education, office of State Office of Prevention, Intervention, Health and Wellness Program. 721 students participated from grades 6 through 12. Key findings from this survey are outlined in Attachment C. Of note, 38% of 6<sup>th</sup> and 7<sup>th</sup> grade respondents reported having more than one sip of beer, wine, or hard liquor and approximately 69% of those in grades 8 through 12 reported the same. A significant increase was also seen in sexual activity with 10% of respondents in grades 6 and 7 reported as having engaged in sex compared to 43% of those in grades 8 through 12 (Attachment 2).

## **Cross-cutting/Life course**

### Oral Health

Dental services that were available at clinics administered by the Department of Health were suspended in 2011 and have not resumed. The Federally Qualified Health Centers have been filling the gaps in Dental services and provide examinations, fluoride applications, fillings and extractions to the children and families who have Medicaid and who are underinsured or uninsured. The School Based Preventive Program was discontinued due to the resignation of the dentist at the start of 2010 and the position has not been filled to date. There is one Pediatric Dentist that continued to provide limited Pediatric services for the MAP clients that were under three years of age and who were in need of serious dental restoration.

The Title V Program provided financial assistance for CSHCN requiring surgical or periodontal treatments who were not covered by the Medical Assistance Program or who were uninsured. The 330 FQHC centers continue to provide dental services to the children and families who have Medicaid and who are underinsured or uninsured. Referrals are made to the only Pediatric Dentist on the island who also provides care to Medicaid patients in order to continue providing access to oral health services, including assessment, oral examination, fluoride applications, restorative fillings and extractions that had been provided by the Dental clinics in the Community Health centers.

### Health Insurance

Access to health services is limited with 28.7% of USVI residents' uninsured, and 24.3 % of children birth to five years uninsured. Individuals in the prime parenting age-group are uninsured at the rate of 53.4% of 18 to 24 year olds and 34.7% of 25 to 34 year olds.<sup>[2]</sup> This estimate is 7% higher than the uninsured rate for the entire US. Health Maintenance Organizations (HMOs) do not exist in the Virgin Islands. Medicaid managed care also does not exist in the territory. The Government of the Virgin Islands, as the largest employer, offers health insurance coverage to its employees. Health insurance fees and increased costs of government health insurance continue to be a barrier for low-income families.

The VI Bureau of Economic Research, Office of the Governor in the US Virgin Islands (USVI) contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health, to conduct the 2009 Virgin Islands Health Insurance Survey. The telephone survey was conducted to assess current rates and types of health insurance coverage among adults and children in the US Virgin Islands. The 2009 survey was comparable to a survey undertaken in 2003, allowing for some comparisons in rates over time. This study found that in 2009, approximately 28.7% (33,000) people were uninsured, up from 24.1% in 2003. This estimate is significantly higher than 7% higher than the rate for the entire US. 21% of the VI population was uninsured for the entire year. This is 9% higher than the equivalent measure for the entire US population.

Based on information collected in fiscal year 2009, an estimated 66% of children accessing services at the MCH program had Medical Assistance; 28% had no coverage and the remaining 6% had private or other group insurance. Any efforts to address elimination of health disparities in this population are severely hampered by stringent eligibility criteria of the Medical Assistance Program.

The poverty threshold for annual allowable income to qualify for Medicaid in the VI is \$9,500 for a family of five compared to the national average of \$23,497 (Census Bureau 2004) for a family of five. This 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 and therefore not as likely to seek early prenatal care which may contribute to poor birth outcomes. The actual cost of providing Medicaid services to this population who would otherwise meet eligibility criteria is unknown.

Economic changes have led to changes in health care insurance coverage. A 2012 study revealed a major drop in employer group insurance and an increase in coverage through public programs, such as Medicaid and Medicare. The number of uninsured increased from 28.7% to 29.7%, with 18.8% of children birth to five years uninsured. Individuals in the prime parenting age group are uninsured at rates of 39.4% for 18 to 24 year olds and 45.4% for 25 to 34 year olds (ECAC Strategic Report 2014).

### **Title V Program Capacity**

The Department of Health's mission is to provide quality health care, regulate, monitor and enforce health standards to protect the public's health. This is achieved by openly communicating with the public, informing them of health care options, thus serving as a catalyst to assist them in making educated choices on receiving the highest quality of health care. As mandated by Virgin Islands Code, Titles 3 and 19, the Department of Health (DOH) has direct responsibility for conducting programs of preventive medicine. The agency is committed to building a sound policy and program infrastructure through employing providers and administrators from every aspect of health care. The Department is the sole state agency responsible for coordinating and providing a focal point for territory wide public health efforts on behalf of Virgin Islanders and visitors to the territory.[1]<sup>3</sup>

The three main facilities for primary care services are MCH & CSHCN Clinics, PHS 330-Community Health Centers, and hospital-based Community Health Clinics. On St. Thomas MCH's principal facility is located in the western district, the Community Health Clinics at the Roy L. Schneider Hospital serve the mid-island district, and the East End Health Center is located in the east district. On St. Croix, the Frederiksted Health Center is located in the western end of the island, and the MCH & CSHCN principal facility is located in the east at Charles Harwood Complex. On Cruz Bay, St. John, the Morris De Castro Clinic is the site for the MCH & CSHCN monthly Infant/Pediatric high-risk clinic.[3]

### **A. Organizational Structure**

The Maternal and Child Health Block Grant is authorized by Title V of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239. The Block Grant Funds assist the Virgin Islands in maintaining and strengthening its efforts to improve the health of all mothers, infants, and children, including children with special health care needs. The U.S. Virgin Islands Department of Health is the official Title V agency for the Virgin Islands.

The Virgin Islands health care system consists of two semi-autonomous hospitals, nursing homes, outpatient clinics, home health care services, hospices, providers, and health educators among others. As a public health department, the goal is to improve the health status of every Virgin Islands resident and to ensure access to quality health care. This includes helping each person live a life free from the threat of communicable diseases, tainted food, and dangerous products. To assist in this mission, activities include regulation of health care providers, facilities, and organizations, and management of direct services to patients where appropriate.

The VI Department of Health (VIDOH) serves the community as both a local and state health department. It consists of two major divisions – Public Health Services and Health Promotion & Statistics. Unlike other state health

departments on the U.S. Mainland VIDOH provides health services in three community health centers territory wide. In addition, the department has nine boards that license and regulate health care professionals. The central office is located on St. Thomas.

The Virgin Islands Department of Health (VIDOH) is designated as the agency in the Virgin Islands for administering the Maternal and Child Health and Children with Special Health Care Needs Program (MCH & CSHCN) pursuant to Title 19, Chapter 7, Section 151 of the Virgin Islands Code. The Maternal and Child Health & Children with Special Health Care Needs (MCH & CSHCN) Program activities are directed at improving and maintaining the health status of women, infants, children, including children with special health care needs and adolescents.

The Title V MCH & CSHCN Program administratively is one integrated program within the Department of Health. This allows for more efficient use of limited human and fiscal resources and better collaboration and coordination of services in MCH. The program provides and coordinates a system of 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 care that includes 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.

#### **A. MCH Workforce Development and Capacity**

The MCH & CSHCN program offers a system of family-centered, coordinated, community-based, culturally competent care, assuring access to child health services that includes medical care, therapeutic and rehabilitative services, care coordination, home visiting, periodic screening, referrals and access to a medical home for children ages birth-21 with disabilities and chronic conditions. Services are provided either directly through Title V or by referral to other agencies and programs that have the capability to provide medical, social, and support services to this population. Public Health Nurses provide assessments, anticipatory guidance, parental counseling, education regarding growth and developmental milestones, proper nutrition practices, immunizations; service / care coordination, and home visiting services to high risk children and their families.

Residents of the territory 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 does not provide these services, due to the Medicaid Cap imposed by Congress. These services are provided on a limited case by case basis by the Title V Program when required.

Nursery referrals are received on all high-risk newborns who are followed in the MCH & CSHCN clinics in both districts. Infants without any high-risk factors are referred to well child clinics. Infants classified as high-risk or at-risk for a disability due to biological, physiological, or environmental factors or diagnosed with medical conditions are followed in the Infant High Risk clinics. High-risk referral patients are screened to receive a home visit, and family assessment. The primary barrier to the home visiting program is insufficient staff to address the increased needs of the high risk population and requests for home visits.

Screening is conducted by program staff to identify children with developmental delays at the earliest age possible, preferably right after birth. Public health nurses assess the developmental needs of infants and toddlers who are 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 in order 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.

The Charles Harwood Complex is the principal site for MCH service delivery on St. Croix. This complex houses

approximately three hundred employees representing several programs and divisions. Prenatal services in 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 for evaluation and treatment. In-patient deliveries are performed by the hospital's Obstetricians and Midwives. Diagnostic services, such as ultrasounds and laboratory services, are provided for MCH clients by the hospitals or private facilities. The government does not operate a public health laboratory on either island outside of the hospital facilities.

On St. Croix, prenatal care capacity consists of one Nurse Midwife, one Obstetrician (vacant), and a Territorial Perinatologist (.1FTE) at the MCH Clinic. The Ob /Gyn performs the initial medical evaluation, manages medically complicated patients, and provides limited gynecological services. The program is actively recruiting a certified nurse-midwife for both districts. However, salaries and compensation are not comparable to the U.S. mainland creating challenges to filling these positions. On St. Thomas, prenatal services are administered by the Community Health Clinics with one Midwife, one Nurse Practitioner, an Obstetrician, and Perinatologist (.1FTE). The Perinatologist also serves as the Director of Women's Health and conducts clinics at St. Thomas East End Medical Center, Frederiksted Health Center, and at the Morris F. deCastro Clinic on St. John. The St. Thomas / St. John district did not meet the minimum score to be designated as an underserved area. However, the Bureau of Health Professions does allow for individuals eligible for Loan Repayment to be recruited and employed.

Patients are referred to the WIC Special Nutrition Program for dietary assessments, counseling, and follow-up. Dental services are provided at Charles Harwood, on St. Croix, and Community Health Services located at the Roy Lester Schneider Hospital, on St. Thomas and are operated under the auspices of the Division of Dental Health Services. Social workers assist patients with assessments, and applying for Medicaid and other services.

Health services are offered through a system, which employs a variety of health care professionals to include Pediatricians, Nurses, Pediatric Nurse Specialist, Clinical Care Coordinators, Social Workers, Dentists, and Dental Hygienists. Allied health professionals may serve territorially when necessary.

The three main facilities for primary care services are MCH & CSHCN Clinics, PHS 330-Community Health Centers, and hospital-based Community Health Clinics. On St. Thomas MCH's principal facility is located in the western district, the Community Health Clinics at the Roy L. Schneider Hospital serve the mid-island district, and the East End Health Center is located in the east district. On St. Croix, the Frederiksted Health Center is located in the western end of the island, and the MCH & CSHCN principal facility is located in the east at Charles Harwood Complex. On Cruz Bay, St. John, the Morris De Castro Clinic is the site for the MCH & CSHCN monthly Infant/Pediatric high-risk clinic.

Through a series of outreach activities, the MCH & CSHCN Unit identifies children who have health problems requiring intervention, are diagnosed with disabling, or chronic medical conditions, or are at risk. A system of public health nursing, based on specified health districts, is an integral component of providing family-centered, community health services. Sources of child-find include referrals from the Queen Louise Home for Children, Early Childhood Education, Head Start, and Private Providers. Pediatricians, Nurses, Social Workers, a Physical Therapist Assistant, an Occupational Therapist, Audiologists, 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 re-assessed 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 Denver Developmental Screening Tool. Social Workers complete an assessment of the family and home environment, existing support structures, and financial status. A diagnostic assessment and therapeutic plan is developed by the clinical staff. Through an appointment system, children with special health care needs are referred to the subspecialty clinics by the primary care physician. The Physical Therapist serves territorially. The Speech Pathologist on St. Thomas may travel to St. Croix to provide services and conduct screening.

The MCH & CSHCN Program continues to suffer from a lack of adequate medical staff, patient load has significantly decreased on the island of St. Croix. There are currently two fulltime pediatricians serving the pediatric patients on St. Thomas/St. John. On St. Croix, both fulltime physicians were lost in 2013. Currently, a nurse midwife and perinatologist see prenatal patients on a weekly basis, with one pediatrician (the MCH Director) filling in the gap as needed for the pediatric patients.

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[1] U. S. Virgin Islands Kids Count Data Book 2009.

[2] Results from the 2009 Virgin Islands health Insurance Survey (January 2010).

[3] Title V Block Grant Annual Report 2009

## **II.B.2. Findings**

### **II.B.2.a. MCH Population Needs**

Great.

### **II.B.2.b Title V Program Capacity**

#### **Title V Program Capacity**

The Department of Health's mission is to provide quality health care, regulate, monitor and enforce health standards to protect the public's health. This is achieved by openly communicating with the public, informing them of health care options, thus serving as a catalyst to assist them in making educated choices on receiving the highest quality of health care. As mandated by Virgin Islands Code, Titles 3 and 19, the Department of Health (DOH) has direct responsibility for conducting programs of preventive medicine. The agency is committed to building a sound policy and program infrastructure through employing providers and administrators from every aspect of health care. The Department is the sole state agency responsible for coordinating and providing a focal point for territory wide public health efforts on behalf of Virgin Islanders and visitors to the territory.[1]<sup>3</sup>

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[1] Title V Block Grant Annual Report 2009

## **II.B.2.b.i. Organizational Structure**

### **A. Organizational Structure**

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The Virgin Islands Department of Health (VIDOH) is designated as the agency in the Virgin Islands for administering the Maternal and Child Health and Children with Special Health Care Needs Program (MCH & CSHCN) pursuant to Title 19, Chapter 7, Section 151 of the Virgin Islands Code. The Maternal and Child Health & Children with Special Health Care Needs (MCH & CSHCN) Program activities are directed at improving and maintaining the health status of women, infants, children, including children with special health care needs and adolescents.

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### **II.B.2.b.ii. Agency Capacity**

Agency capacity is 300 persons within the DOH structure.

### **II.B.2.b.iii. MCH Workforce Development and Capacity**

The MCH & CSHCN program offers a system of family-centered, coordinated, community-based, culturally

competent care, assuring access to child health services that includes medical care, therapeutic and rehabilitative services, care coordination, home visiting, periodic screening, referrals and access to a medical home for children ages birth-21 with disabilities and chronic conditions. Public Health Nurses provide assessments, anticipatory guidance, parental counseling, education regarding growth and developmental milestones, proper nutrition practices, immunizations; service / care coordination, and home visiting services to high risk children and their families.

Residents of the territory 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 does not provide these services, due to the Medicaid Cap imposed by Congress. These services are provided on a limited case by case basis by the Title V Program when required.

Nursery referrals are received on all high-risk newborns the MCH & CSHCN clinics in both districts. Infants without any high-risk factors are referred to well child clinics. High-risk referral patients are screened to receive a home visit, and family assessment. The primary barrier to the home visiting program is insufficient staff to address the increased needs of the high risk population and requests for home visits.

Public health nurses assess the developmental needs of infants and toddlers who are at-risk due to psychosocial or biological risk factors. a referral to the early intervention services program Infants and Toddlers' (Part C of IDEA) service coordinator. 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.

The Charles Harwood Complex is the principal site for MCH service delivery on St. Croix.

Prenatal services in 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 for evaluation and treatment. In-patient deliveries are performed by the hospital's Obstetricians and Midwives. Diagnostic services, such as ultrasounds and laboratory services, are provided for MCH clients by the hospitals or private facilities.

On St. Croix, prenatal care capacity consists of one Nurse Midwife, one Obstetrician (vacant), and a Territorial Perinatologist (.1FTE) at the MCH Clinic. On St. Thomas, prenatal services are administered by the Community Health Clinics with one Midwife, one Nurse Practitioner, an Obstetrician, and Perinatologist (.1FTE). The St. Thomas / St. John district did not meet the minimum score to be designated as an underserved area. However, the Bureau of Health Professions does allow for individuals eligible for Loan Repayment to be recruited and employed.

## **II.B.2.c. Partnerships, Collaboration, and Coordination**

### ***I. Partnerships, Collaborations, and Coordination***

The MCH & CSHCN Unit plays a leadership role in developing a comprehensive system of service. Agency and community resources include Human Services, Developmental and Disabilities Council, Department of Justice (Office for Paternity & Child Support), Department of Education, Special Education / Early Childhood Program, Head Start Program, and Disabilities and Rehabilitation Services. The V.I. Advocacy Agency, Inc., and Legal Services provide an effective voice for persons with disabilities. Representatives of these agencies serve on the MCH & CSHCN Advisory Council, V.I. Interagency Coordinating Council, and the V.I. Alliance for Primary Care, and

participate in planning and evaluating services for children with special health care needs.

Several government agencies, programs, foundations or community based organizations provide services to this vulnerable population comprised of women in their reproductive age, children and adolescents especially those with special health care needs. Appropriate coordination among all concerned agencies is vital in order to reduce duplication of effort and fragmentation of services, and to be more efficient in the use of limited resources. The VIDOH has established formal and informal relationships with other public agencies, academic institutions, and health care facilities. These relationships enhance the availability of comprehensive services for the MCH population. There are also memorandums of understanding among agencies and programs, which enhance coordination of services.

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

The Maternal, Infant, and Early Childhood Home Visiting Program has provided the US Virgin Islands (USVI) with the ability to service and collectively impact some of the Territory's most at risk families by supporting the implementation of evidenced based programs, providing needed jobs and capacity building in the field of early childhood.

### **States Supplemental Data Initiative (SSDI)**

The 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, including children and youth with special health care needs.

### **Early Hearing Detection and Intervention (EHDI)**

The primary emphasis of the project is to reduce the percent of infants lost to follow-up after missed initial screening or referral for repeat screening, and develop a tracking system to ensure they are rescreened and referred for timely diagnostic evaluation, treatment, and early intervention services.

### **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.

### **Infant and Toddlers Program**

The Infants and Toddlers Program supplements the Maternal Child Health and Children with Special Health Care Needs (MCH & CSHCN) Program, when public or private resources are otherwise unavailable, providing early intervention services such as: service coordination, physical and occupational therapy, speech and language pathology, vision therapy, special instruction, and family training.

### **Women, Infants and Children Program**

The VI WIC Program remains dedicated to provide family-centered nutrition education and services to WIC participants/caretakers in order that optimal growth and development of infants and children occur, and to assist in prenatal, postpartum and breastfeeding women making informed health and dietary choices for themselves and their families. An 86% partial breast-feeding rate among WIC post-partum participants was maintained. Exclusive breastfeeding rate is at 3%.

### **Family Planning Program**

The VI Family Planning Program seeks to ensure efficient and high quality reproductive health care services including family planning as well as the related preventive and medical treatment that will improve the overall health of individuals. It facilitates access to health information to encourage healthy responsible behavior among at risk youth's age 10-21 years. VIFPP is a forerunner in the encouragement and empowerment of families through proactive involvement in healthy behavior and disease prevention. The program directly impacts more than 5,000 individuals while indirectly impacting 25,000 children, youth, parents, and community residents in the United States Virgin Islands.

### **Medicaid Program**

The VI Medicaid Program is the central source of health care for the Virgin Islands' most vulnerable residents: the aged, blind, disabled individuals and low income families who cannot afford to pay for their own health care needs. Eligibility is based on family income, available resources, and other factors. As the payer of last resort, the MCH & CSHCN Program is fiscally linked to the Medical Assistance Program. The Medical Assistance Program (MAP) functions under a congressionally imposed cap with a ratio of Federal and Local matching of 50/50. Mandatory Medicaid services include inpatient hospital, outpatient hospital, health clinic services, laboratory & x-ray services, Early & Periodic Screening, Diagnosis & Treatment (EPSDT), Family Planning, Nursing Home Services, Physician Services that must be pre-authorized, and Dental services. Optional services (but covered) include: optometrists, eyeglasses, prescribed drugs, air transportation, and respiratory therapy. Optional services (not covered) include: services in institutions for mental illness, hospital transfer/air ambulance transportation, dentures prosthetic devices, physical and occupational therapy, and/or durable equipment.

### **Role of the Parents**

Parents play a vital role in the program planning and evaluation, quantitatively, and qualitatively. Parents are involved in preliminary planning and implementation of each program. There are parent representatives on the MCH Advisory Council and the V.I. Interagency Coordinating Council. Here to Understand & Give Support (HUGS-VI) is a Parent Support Group for parents and caregivers of individuals with Special Needs. HUGS mission is to bring families and partners together to empower those with disabilities through learning, sharing, recreation and social events. HUGS-VI offers training programs about Special Education rights, and other programs that encourage those with disabilities to maximize their living potential. Parents also champion the Sickle Cell Associations in the Territory with ongoing monthly meetings.

### **V.I. Interagency Coordinating Council**

The V.I. Interagency Coordinating Council (VIICC) is charged with the task of advising and assisting the Department of Health in the implementation of the Individuals with Disabilities Education Act. The VIICC includes representatives of state public agencies, such as the Department of Health, MCH & CSHCN, Department of Human Services, Department of Education, Special Education/Early Childhood Education, University of the Virgin Islands,

public and private providers, advocacy agencies, parents of children with disabilities, and the V.I. Legislature. An Interagency Memorandum of Understanding with the Departments of Health, Human Services, and Education coordinates the early intervention services for children under three years. This agreement is to be revisited to include children 0 – 5 years.

### **Early Childhood Advisory Committee**

Early Childhood Advisory Committee (ECAC): An interagency advisory committee established by the Office of the Governor to fulfill the mandates in the Improving Head Start for School Readiness Act to improve the lives of young children and their families. The purpose is to develop an agenda for improvements in child care and early childhood education that improves school readiness.

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

Established in October 1994 the Center was funded by the US Department of Health and Human Services, Administration on Developmental Disabilities and the US Department of Education, Office of National Institute on Disability and Rehabilitation Research.

The VIUCEDD 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 our special needs population. In 2014, their Annual Autism Conference featured Dr. Georgina Peacock, Medical Officer and Developmental-Behavioral Pediatrician, from the Centers for Disease Control and Prevention's National Center on Birth Defects and Developmental Disabilities.

### **Vocational Rehabilitation Program**

The Vocational Rehabilitation Program is authorized by the Rehabilitation Act of 1973, Public Law 93-112 and its amendments. The program is administered by the Department of Human Services. The program offers services 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.

### **Developmental Disabilities Council**

The Developmental Disabilities Program is authorized under Public Law 106-402, the Developmental Disabilities Assistance and Bill of Rights Act of 2000. The purpose of this act 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.

### **Office of Child Care & Regulatory Services**

The Department of Human Services, Office of Child Care & Regulatory Services, in collaboration with several

partner agencies, works to improve the quality of child care in the territory and to ensure that quality child care is accessible to all families in the Virgin Islands. These goals 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. Using a sliding scale, eligibility is determined and subsidized child care is provided for the territory's eligible low income families through the voucher reimbursement program. This program serves infants to after school children from birth to age 13. Additionally, child care providers receive technical assistance and support to enhance and promote high quality early care and education in the territory.

## II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents.	Continued	
2	Increase the percentage of families that participate in transition planning	Continued	
3	Increase the number of women that have well women visits	New	
4	Increase the number of women still breastfeeding until 6 months	New	
5	Increase access to oral health care for the Maternal and Child population	New	
6	Decrease the number of children with BMI > 85%	New	
7	Increase the number of families educated on safe sleep practices	New	
8	Increase the percent of developmental screenings done in the territory	New	
9	Decrease the number of teenage pregnancies	New	

### VI STATE SELECTED PRIORITIES

After reviewing the data from the Needs Assessment and the data obtained from the various health clinics in the territory, as well as the information provided from discussions with MCH partners, the Virgin Islands MCH & CSHCN identified the following nine (9) needs as top priority needs for primary and preventive care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for children with special health care needs. The MCH team prioritized these needs in the following manner and decided to allocate the resources to address them.

- To increase access to primary and preventative services for adolescents and young adults.

- To increase the percent of CSHCN families' participation in transition planning to at least 50%.
- To increase the percentage of women that breastfeed exclusively initially and up to 6 months of age.
- To improve access to primary and preventive oral health care services for all segments of the MCH population.
- Promote healthy lifestyle practices and reduce the rate of overweight children (BMI > 85%).
- To increase the number of women that receive a well woman's visit.
- Enhance efforts to increase education about safe sleep practices.
- Increase the percent of individuals screened routinely.
- To decrease the number of teenage pregnancies in the territory

There are many needs in the territory but the adolescent population and the children with special health care needs are the most vulnerable populations in that they lack both adequate access to health care and adequate services to meet their needs. Given the data obtained from the Needs Assessment about the adolescents in the territory of the Virgin Islands, and the fact that some of the teenagers reported that discussions about these various risky behaviors were helpful, the MCH team was compelled to make Adolescent Health Care a priority by providing more services and more education – ways to effectively impact the adolescents in the territory.

During FY 2014, 1,133 adolescents between the ages of 15-19 yrs out of an estimated population of 5,798 ( 2012 VI Census) (20%) attended either one of the Federally Qualified Health Care Centers (FQHCs) or MCH clinics for an adolescent well health visit. An adolescent well visit is an opportune time to provide the recommended clinical preventive services, including screening, counseling, and immunizations. It is an opportune time to address psychosocial issues and provide education regarding healthy behavior in the areas of sex, drugs, and interpersonal relationships. If behaviors are to change, then access to services must increase for this population. But the services and education provided must also include parents especially since data from the needs assessment indicate that youth do not perceive their parents as setting rules or expectations with respect to drugs and alcohol, whereas schools do. With parental education, consistency across all settings in which a young person grows might be achieved and hence reduce some high-risk behavior, especially in view of the fact that adolescents are less likely to engage in activities/behaviors that are disapproved of by their parents. There are great opportunities to provide access to healthcare for adolescents through the FQHCs. Freedericksted Health Center has a school based center at one of the major public schools in St. Croix. East End Health Center is partnering with Family Planning to go into the Public High Schools and provide healthcare for the adolescents.

The area of transition is still an area that requires more coordination and collaboration to ensure that these children continue to receive adequate and appropriate services once they transition into adulthood. In these difficult economic times, strengthening partnerships to pool financial and personnel resources would be beneficial to the programs, the families and the children of the territory. Without good outreach and educational programs for the community and for the community based organizations that serve the various populations in the territory, there would be no standard of health care being administered. The problem of obesity is a national problem. The continued increase in childhood obesity in children under the age of 5 years continues to be associated with serious morbidity and mortality in some cases. Head Start data revealed that 68/600 (11%) children enrolled in Head Start between the ages of 3-5years were overweight (85% were obese. Because of the risk factors of obesity (Hypertension, Diabetes, High Cholesterol and Cardiac Disease) the continued promotion of healthy lifestyles is a definite priority.

It has been proven that breastfeeding provides many important benefits to the newborn regardless if the infant is premature or full term. Human milk is said to support optimal growth and development since it provides all the necessary nutrients required for the infant during the first six months of life. Because it decreases the risk of SIDS, boosts the infant's immune system and even the immune response to vaccines, it is very important that breastfeeding be a part of the seven priorities for the VI. The WIC data shows 85% of their clients exclusively breastfeed initially, however, it is unclear how many of them continue to exclusively breastfeed until 6 months. Many

mothers face challenges such as going back to work within 6 week of delivery and are not able to continue exclusively breastfeeding or exclusively providing breast milk since many places of employment are not set up to allow for breast pumping.

With the SIDS/SUID being ranked as one of the leading causes of infant mortality, it is imperative that the territory increase awareness and provide education regarding safe sleep practices. Partnerships with many of the Early Childhood programs and care providers make it very feasible to educate and promote awareness within the community. As part of the COIIN Initiative for Infant Mortality, the Advisory group will work towards getting a better understanding regarding the contributing factors for VI infant mortality.

Oral health care is nationally the greatest unmet childhood need. Nationally, there is a lack of adequate and effective preventive oral health services. Poor oral health can affect a child's, pregnant woman's overall general health; a child's learning ability; ability to socialize; and emotional stability. Because it is such an important component of one's general health and well-being, it was chosen was one of our top priorities. Based on the percentage of children that are seen in the clinics and the fact that there are months long waiting lists at the FQHCs, the needs of women and children are definitely not being met. Pregnant mother reported in the Needs Assessment that they did not see a dentist during their pregnancy. Tooth decay is still the most prevalent oral problem in the Pediatric population here at the MCH clinics, but the children do not get seen quickly because of the lack of sufficient Dentists, especially Pediatric Dentist. There is only one Pediatric Dentist in the entire territory. This poses significant challenges, but it is a need that must be addressed.

Other priorities that came up but are difficult to address are: lack of adequate health insurance for low income families. There is a Medicaid cap and the territory does not get SCHIP; therefore, there are many families that remain uninsured and under insured. According to the VI Community Survey of 2012, there are 7,616 children between the ages of 0 and 19 yrs that have no insurance out of an estimated population of 26,500 in that age group (29%). The MCH program can only continue to assist these needy families financially in accessing health care. With continued budget cuts both Federally and locally, it continues to be very challenging to support the needs of many of these children. There are also significant needs surrounding Mental Health and MCH has been partnering with the Division of Mental Health and SAMSHA to address some of these needs; particularly in the area of substance abuse and behavioral issues. The MCH program is sponsoring an Adolescent Health Summit to provide education on Trauma informed care- focusing on the adolescent and utilizing a positive youth development model in adolescent health. However, the needs are so great that it is essential to prioritize and consider the work force capacity to address these needs.

**II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures**

**NPM 1-Percent of women with a past year preventive medical visit**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.0	35.0	40.0	45.0	50.0

**NPM-4 A) Percent of infants who are ever breastfed**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	85.0	90.0	95.0	98.0	100.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	85.0	90.0	95.0	98.0	100.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	60.0	65.0	70.0	75.0	80.0

**NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	45.0	50.0	55.0	60.0

**NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	30.0	35.0	40.0	45.0	50.0

**NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	75.0	80.0	85.0	90.0

**NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	35.0	40.0	45.0	50.0	55.0

**NPM-13 A) Percent of women who had a dental visit during pregnancy**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.0	30.0	35.0	40.0	45.0

**NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	75.0	80.0	85.0	90.0

## Linkage of VI State Selected Priorities with National Performance and Outcome Measures

### **I. Health Domain: Women's Health:**

One of the top priority needs for the VI based on the Needs Assessment and Data collected from Vital Statistics is to decrease Teen Pregnancy. This priority need is linked to National Performance Measure #1: Percent of Women with a past year preventive visit. In order to effectively address this priority, concepts from the life course model must be utilized such that health is optimized across the lifespan of the adolescent to womanhood and infancy when the adolescent becomes a mother. The goal is also to eliminate the health disparities that exist across the populations and communities. The best approach is to begin with preconception health care that impacts so many aspects of the teenager's life and the life that she produces. But preconception care has to be a part of a bigger system of health care – well woman's visit.

Preconception health care, which is the medical care a woman or man receives from the doctor or other health professionals that focuses on the parts of health that have been shown to increase the chance of having a healthy baby, is important for every woman—not just those planning pregnancy. It means taking control and choosing healthy habits. It means living well, being healthy, and feeling good about your life. Preconception health is about making a plan for the future and taking the steps to get there! Preconception health care is very important in not only producing better pregnancy outcomes, but better birth outcomes also. Preconception health is a precious gift to babies. For babies, preconception health means their parents took steps to get healthy before pregnancy. Such babies are less likely to be born early (preterm) or have a low birth weight. They are more likely to be born without birth defects or other disabling conditions. Preconception health gives babies the best chance for a healthy start in life.<sup>9</sup> Preconception care is also an important aspect in providing teens with more knowledge about making better choices with respect to their sexual health and unplanned pregnancy. Well women health decrease the risks of chronic diseases such as diabetes, obesity and hypertension and hence decrease the risk of low birth and premature infants.

### **II. Health Domain: Perinatal/ Infant Health**

Under this health domain, the VI had two priorities needs based on the Needs Assessment; data collected from WIC; and data collected from the MCH Clinics. The priority needs are (1) Increase the number of infants that exclusively breastfeed until 6 months and (2) increase parental awareness of safe sleep habits. These priority needs are linked to National Performance Measure #4: a)Percent of infants who are ever breastfed and b) percent of infants breastfed exclusively through 6 months and linked to National Performance Measure #5: Percent of infants placed to sleep on their backs.

The WIC data demonstrates that they have been effective in increasing breastfeeding rates over the past few years up to the point where 81% of their clients breastfeed. However, the data is unclear as to whether the clients are exclusively breastfeeding up to 6 months. The WIC program itself does not have the capability to collect that data. The CDC used to collect that specific data for the VI and publish it through the Pediatric Nutrition Surveillance System (PedNSS), but they no longer collect the data for the VI, so we don't not have an accurate number. We do know that many women are part of the working force and have reported anecdotally that they are unable to continue exclusively breastfeeding because the infants have to be placed in daycare and many are unable to breast pump at work.

With respect to safe sleep habits, the VI is part of the Region II Infant Mortality COIIN Initiative and SUID/ SIDS plays a significant role infant mortality. According to the CDC, SIDS is the leading cause of death in infants 1-12 months old. Approximately 3,500 US infants die suddenly and unexpectedly each year. We often refer to these deaths as sudden unexpected infant death (SUID). Although the causes of death in many of these children can't be explained, most occur while the infant is sleeping in an unsafe sleeping environment. 40% of VI infants were reportedly exclusively put to sleep on their backs. Many parents reported putting infants to sleep either on their sides or their

backs. The parents from the MCH clinics did not fully understand all the things that are needed to provide a safe sleep environment, such as having a firm mattress with a fitted sheet and no blankets, etc. the MCH program intends to go beyond just placing infant on the back, and emphasize providing a safe sleep environment. The VI Infant mortality rate reported in 2012 by the National Vital Statistics Survey (NVSS) was 8.5 (12 infant deaths out of 1415 live births). For 2011, the NVSS reported a rate for the VI of 8.1 (12 infant deaths out of 1491 live births). In 2010 the US infant mortality rate was 6.1.

Focusing on both safer sleep environments and breastfeeding can significantly impact infant mortality, especially since according to the CDC, breastfeeding is also a protective factor against SIDS/SUIDS. The MCH program intends to go beyond just placing infant on the back, and emphasize providing a safe sleep environment.

### **III. Health Domain: Child Health:**

Under this health domain, the VI's priority need based on the Needs Assessment; data collected from WIC; data collected from Head Start; and data collected from the MCH Clinics is to decrease the number of children with a BMI > 85% and to increase the percent of children screened. These priority need measures are linked to NPM #8 and 6, respectively: The percentage of children ages 6 through 11 yrs and adolescents ages 12 through 17 yrs who are physically active at least 60 minutes per day and Percent of children ages 10-17 months, receiving a developmental screening using a parent-completed screening tool

According to the CDC, Childhood obesity has more than doubled in children and quadrupled in adolescents in the past 30 yrs.<sup>1, 2</sup> The percentage of children aged 6–11 yrs in the United States who were obese increased from 7% in 1980 to nearly 18% in 2012. Similarly, the percentage of adolescents aged 12–19 yrs who were obese increased from 5% to nearly 21% over the same period.<sup>1, 2</sup> In 2012, more than one third of children and adolescents were overweight or obese.<sup>1</sup>

The immediate effects of obesity are related to increased risk for cardiovascular disease (high cholesterol or high blood pressure). In a population-based sample of 5- 17-year-olds, 70% of obese youth had at least one risk factor for cardiovascular disease.<sup>7</sup> Obese adolescents are also more likely to have prediabetes,<sup>8,9</sup> and are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self-esteem.<sup>5,6,10</sup> Long-term health effects include obesity as adults<sup>11-14</sup> and hence, increased risk for adult health problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.<sup>6</sup>

WIC and Head start data for the VI has demonstrated that even before the age of 6 years, at least 112/600 children were overweight. Behaviors and habits are formed in the early formative years and hence it is imperative to begin focusing not only on the 6- 11 yr olds and the adolescents only, but also on the 2-5 yr olds because by the time they are 6 yrs, and in the adolescent age group, it is too late. Therefore, the MCH program will concentrate on the WIC and Head Start populations and their families to impact the older groups. The program will continue to provide education for the 6-11 yr olds and the adolescent group as they tend to be more sedentary.

Citations found at: <http://www.cdc.gov/healthyyouth/obesity/facts.htm>

### **IV. Health Domain: Adolescent/Young Adult Health**

Under this health domain, the VI's priority need based on the Needs Assessment; data collected from the MCH Clinics; and data from the 2010 Youth Behavior Risk Survey is to increase access to primary/ preventive health care for the adolescent population. This priority measure is linked to NPM#:10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

The adolescent period is a tremendous time of transition physically, mentally, emotionally and socially. This is a time period that they should begin assuming personal responsibility for their health and well being. It is a period of risk

taking as adolescents try to take on adult roles and behaviors. According to a 2010 Youth Risk Behavior Survey (YRBSS) conducted in students in grades 6<sup>th</sup> to 12<sup>th</sup> for the St. Thomas/St. John Public School District, 38% (273 out of 721) 6<sup>th</sup> and 7<sup>th</sup> graders reported having had a sip or two of beer, wine, or hard liquor and approximately 69% (497 out of 721) of those in grades 8<sup>th</sup> through 12<sup>th</sup>. When asked about sexual relationships, 10% (72 out of 721) of 6<sup>th</sup> and 7<sup>th</sup> graders had engaged in sex and 43% (310) of 8<sup>th</sup> through 12<sup>th</sup> graders.

Receiving health care services annually will be instrumental in helping adolescents adopt and maintain healthy behaviors, manage and/or prevent chronic diseases and decrease engagement in risky behaviors. Partnering and supporting Family Planning efforts to engage adolescents to take responsibility for their own health care. Adoption of the Bright Futures guidelines during health visits will ensure that all topics relevant to this population are covered.

One of the top priority needs for the VI based on the Needs Assessment and Data collected from Vital Statistics is to decrease Teen Pregnancy. This priority need is linked to National Performance Measure #1: Percent of Women with a past year preventive visit. In order to effectively address this priority, concepts from the life course model must be utilized such that health is optimized across the lifespan of the adolescent to womanhood and infancy when the adolescent becomes a mother. The goal is also to eliminate the health disparities that exist across the populations and communities. The best approach is to begin with preconception health care that impacts so many aspects of the teenager's life and the life that she produces. But preconception care has to be a part of a bigger system of health care – well woman's visit.

In 2013, a total of 273,105 babies were born in the U.S. to women aged 15–19 years, for a live birth rate of 26.5 per 1,000 women in this age group.<sup>1</sup> Birth rates in the U.S. fell 13% for women aged 15–17 years, and 8% for women aged 18–19 years. Although this is a record low for U.S. teens within this age group, representing a drop of 10% from 2012, the U.S. teen pregnancy rate is still substantially higher than in other western industrialized nations.<sup>2</sup> Since the VI rate is higher than the national rate, this has to be a priority for the MCH program.

Together, black and Hispanic teens comprised 57% of U.S. teen births in 2013.<sup>1</sup> Not surprisingly, The vast majority (8 in 10) of all pregnancies among adolescents are either unplanned or occurred before the adolescents were ready to be parents.<sup>3</sup> In order to avoid unplanned pregnancies, it is essential for adolescents who are sexually active to use effective contraceptives (such as condoms, birth control pills, the patch, the vaginal ring, the IUD, and injectable birth control methods) and to use them every time they have sex.

While reasons for the declines in teen births are not clear, teens seem to be less sexually active, and sexually active teens seem to be using birth control than in previous years.<sup>4</sup> Evidence-based teen pregnancy prevention programs typically address specific protective factors on the basis of knowledge, skills, beliefs, or attitudes related to teen pregnancy.

Additionally, teens need access to youth-friendly clinical services. Parents and other trusted adults also play an important role in helping teens make healthy choices about relationships, sex, and birth control.

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## **V. Health Domain: CYSHCN**

Under this health domain, the VI's priority need based on the Needs Assessment and data collected from the MCH Clinics is to increase the percentage of families participating in transitioning CYSHCN. This priority measure is linked to NPM #12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

More than 90% of adolescents with special health care needs make it to adulthood; however, there are significant challenges in completing high school, attending college or even gaining meaningful employment. With these known challenges and limited support systems once they become an adult, it is imperative that the barriers to navigating the healthcare system and maintaining good health are overcome utilizing an evidence based transitional program. This will result in successful in transitioning from Pediatric to Adult healthcare - the goal of the MCH program.

## **VI. Health Domain: Life Course/ Cross-Cutting**

Under this health domain, the VI's priority need based on the Needs Assessment and data collected from the MCH Clinics is to increase access to oral health for the MCH population. This priority measure is linked to NPM #13: a) Percent of women who had a dental visit during pregnancy and b) percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Oral health is a significant component of good health. In addition to having access to oral health care, practicing good oral hygiene and engaging in good nutritional habits, are essential to maintaining good oral health. Poor oral health puts individuals at risk for other systemic illnesses/diseases and poor immunity. Poor oral health impedes educational, social and physical wellness. Mothers that do not have good oral health care during pregnancy put their unborn infants at risk for infections and poor birth outcomes. Our clinical and hospital data and Needs Assessment show that pregnant females were not getting oral health care during their pregnancy. The data shows that the Pediatric population is not being provided the necessary preventive measures (sealants, fluoride treatments and regular exams) as required.

## **II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures**

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

## **II.F. Five Year State Action Plan**

### **II.F.1 State Action Plan and Strategies by MCH Population Domain**

The Title V Maternal and Child Health Services Block Grant Program is operated as a single Administrative Unit within the Department of Health. The unit is responsible for conducting the statewide assessment of needs, agency management, program planning and implementation, policy development, and interagency collaboration.

In FY '14, MCH & CSHCN administered the following programs:

- Preventive and Primary Child Health Care
- Integrated newborn genetic/metabolic and hearing Screening
- Prenatal Care Services and Care Coordination
- Limited Subspecialty Care Services
- SIDS Counseling
- Audiological, Speech and Physical Therapy Services
- Head Start Screening (Developmental, Hearing, Vision, physical examinations)

Throughout FY'14, the MCH & CSHCN Program continued to promote care coordination and collaboration among programs serving the special needs population. Outreach, education and case management activities for pregnant women were provided.

The MCH & CSHCN Program focuses on the well being of the MCH populations of women and infants, children and adolescents, and children with Special Health Care needs (CSHCN) and their families. The program places an emphasis on developing core public health functions and responding to changes in the health care delivery system. As a territory with significant shortages of pediatric medical services and limited existing services, the Virgin Islands faces many challenges to development of systematic approaches to population based direct care services

State Action Plan Table

Women/Maternal Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Increase the number of women that have well women visits	Decrease Infant Mortality rate and low birth rate	Increase access to pre-conceptual care for this population by partnering with the FQHC's  Educate on healthy sexual behavior and habits  Support Family Planning efforts  Continue to educate women and their partners about overall physical, emotional, psychological and sexual health and the need for women's health	Rate of severe maternal morbidity per 10,000 delivery hospitalizations	Percent of women with a past year preventive medical visit		
	Improve pregnancy and birth outcomes		Maternal mortality rate per 100,000 live births			
	Decrease the number of teenagers that are pregnant by 5%		Percent of low birth weight deliveries (<2,500 grams)			
	Decrease maternal morbidity		Percent of very low birth weight deliveries (<1,500 grams)			
	Improve overall women's health		Percent of moderately low birth weight deliveries (1,500-2,499 grams)			
			Percent of preterm births (<37 weeks)			
			Percent of early preterm births (<34 weeks)			
			Percent of late preterm births (34-36 weeks)			
			Percent of early term births (37, 38 weeks)			

			Perinatal mortality rate per 1,000 live births plus fetal deaths			
			Infant mortality rate per 1,000 live births			
			Neonatal mortality rate per 1,000 live births			
			Post neonatal mortality rate per 1,000 live births			
			Preterm-related mortality rate per 100,000 live births			

**Women/Maternal Health**

**Women/Maternal Health - Plan for the Application Year**

The Family Planning Program will continue to strive to increase awareness on choices and consequences as it relates to sexual involvement. Outreach staff will continue to strive to engage women in taking more responsibility for their health care and encourage pre-conceptual care by targeting the 18-25 year old population.

Encourage male involvement in family planning outreach activities emphasizing shared responsibility and STD/HIV prevention..

The Family Planning Program will continue to provide access to comprehensive services, STD counseling and testing, with special counseling for adolescents.

Outreach and community education efforts will continue to provide information through print, radio and TV media.

Group sessions and other activities are being planned to promote wellness among the women population.

Increase access to women at high risk for unintended pregnancies and STD through the Implementation of Satellite Clinics on St. Thomas/St.John and St. Croix. Expand outreach of the FQHCs to provide access to health care for women.

**Women/Maternal Health - Annual Report**

**NPM 1 - Percent of women with a past year preventive medical visit**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25	35	40	45	50

The Family Planning Program and FQHCs have provided well care to 5103 females between the ages of 12 to 60

years. The Family Planning program is making a concerted effort to provide pre-conceptual care to improve the health and well-being of future Mothers and infants. The Family Planning program is targeting young adults at the University level and high school level. Targeting this population is an effort to get youth to start to take more responsibility for their health. The FQHCs have partnered with the hospitals to provide preventative screening for women - Pap smears, mammograms, and general screening ( Blood pressure, cholesterol and random glucose testing). Many women have been identified with pre-diabetes and pre-hypertension such that interventions in diet and exercise could be implemented.

Prenatal services in 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 for evaluation and treatment. In-patient deliveries are performed by the hospital's Obstetricians and Midwives. Diagnostic services, such as ultrasounds and laboratory services, are provided for MCH clients by the hospitals or private facilities. The government does not operate a public health laboratory on either island outside of the hospital facilities.

On St. Croix, prenatal care capacity consists of one Nurse Midwife, one Obstetrician (vacant), and a Territorial Perinatologist (.1FTE) at the MCH Clinic. The Ob /Gyn performs the initial medical evaluation,

and the Perinatologist manages medically complicated patients, and provides limited gynecological services. On St. Thomas, prenatal services are administered by the Community Health Clinics with one Midwife, one Nurse Practitioner, an Obstetrician, and Perinatologist (.1FTE). The Perinatologist also serves as the Director of Women's Health and conducts clinics at St. Thomas East End Medical Center, Frederiksted Health Center, and at the Morris F. deCastro Clinic on St. John. The St. Thomas / St. John district did not meet the minimum score to be designated as an underserved area.

Under the stewardship of our nurse mid-wife, MCH is developing a centering program to encourage a social structure and support system for pregnant moms. Centering is an evidence-based redesign of health care delivery that helps to promote:

- \* safety,
- \* efficiency,
- \* effectiveness,
- \* timeliness,
- \* culturally appropriate patient-centered care, and
- \* more equitable care.

Centering is a model of group healthcare, which incorporates three major components: assessment, education, and support. Patients meet with their care provider and other group participants for an extended period of time, usually 90-120 minutes, at regularly scheduled visits over the course of their care. Centering promotes greater patient engagement, personal empowerment and community-building. Monthly meetings will be held until 36 weeks pregnancy after which moms will meet together weekly. MCH is also exploring the use of a doula program to work with mothers during their pregnancy, during birth and for 15 hours postpartum.

Postpartum clinic is held every Tuesday with MCH nurses offering wellness and child care consults and counselling. The nurses review the patient's history and any complications in pregnancy and advise them on breastfeeding, safe sleep practices, immunizations, address any concerns on illnesses or failure to thrive, provide guidance on involvement of other children in the home and when they should schedule their next appointment. This service is

offered regardless of where the mother may choose to receive future clinical services.

Virgin Islands Partners for Healthy Communities (VIPHC) remains a key partner in women's health and postpartum outcomes. The Healthy Families...Healthy Babies Initiative (HFHBI) on St. Thomas, played a key role in the lives of 75 families for the year beginning January 1 through December 31, 2013. There were a total of 58 new clients enrolled throughout the year by means of referral, outreach recruitment, and client/former client's telling other of VIPHC services. There were also, 17 clients carried over from December 2012 to January 2013. Of the 75 clients served in 2013, there were 37 deliveries, 2 of which were the result of preterm labor by the end of December 2013. Additionally, there were 2 miscarriages among enrolled clientele during the 2013 year. Of the 37 deliveries for 2013, 2 pre-term births were recorded.

After enrollment, each client stays with the HFHBI 12 weeks postpartum. As such, an individual enrollment period could range from 2 months to 12 months post referral or outreach recruitment. Throughout 2013, VIPHC - St. Thomas staff served an overall average of 31 clients and their families per month. Enrollees were primarily referred to VIPHC from partnering providers: VI Department of Health

– Community Health Center and the St. Thomas East End Medical Center. Additionally, referrals are received from DOH – Nurse Family Partnership Program, VI Department of Human Services – Head Start Program and Bethlehem House Shelter.

On St. Croix, the "Promoting Healthy Families Initiative" saw a reduction in the service population in 2013, due to the loss of a case management position (funding cuts), the unexpected relocation off-island of another staff member and other staffing issues. A total of 231 clients (198 females and 33 males) and their families were served. 72 or 31% of enrollees were high risk pregnant clients, with 61% entering prenatal care in the first trimester, achieved in large part through a strengthened collaboration with the MCH staff. From this population 61 babies were born and 1 miscarriage occurred. 85% of deliveries were normal birth weight and 73% of the 61 births were vaginal. 85% of new mothers initiated breastfeeding, and 70% were still breastfeeding at 3 months post partum. This increase can be attributed to consistent promotion, education, support and collaborative strategies with WIC and JFL to overcome the barriers to breastfeeding faced by clients, especially during the post partum phase. A total of 126 house visits were made for program enrollees.

**State Action Plan Table**

**Perinatal/Infant Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
<p>Increase the number of families educated on safe sleep practices</p>	<p>Increase the number of families that receive educational information or counseling about safe sleep by 5% each year</p>	<p>Educate parents on safe sleep practices at every well-child visit for the first year of life beginning with the post partum visit</p> <hr/> <p>Utilize the Kiosks located in the MCH clinics to promote education for families attending the clinic on safe sleep practices and the benefits of back to sleep position</p> <hr/> <p>Provide educational material and training to other Healthcare Providers including the FQHCs and Home Visiting staff on safe sleep practices</p> <hr/> <p>Provide training to Child care providers on safe sleep habits</p>	<p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	<p>Percent of infants placed to sleep on their backs</p>		

Increase the number of women still breastfeeding until 6 months	Increase the number of women that still breastfeed at 6 months by 5%	Continue to support WIC efforts to maintain breastfeeding until 6 months Continue to promote community awareness on the importance of breastfeeding and the protective factors provided by breastfeeding	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		
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**Perinatal/Infant Health**

**Perinatal/Infant Health - Plan for the Application Year**

The Virgin Islands WIC Program continues all efforts to actively promote, support and protect breastfeeding within the territory. VI WIC continues to remain the ‘beacon of light’ for breastfeeding promotion within the islands, as the only organization, which consistently promotes and supports breastfeeding within the territory. They provided breastfeeding information to all prenatal clients at certification as well as individualized assistance to breastfeeding moms with problems.

Nutrition Education and WIC program materials translated in Spanish are available to serve the Spanish speaking population.

Trends in the breastfeeding rate in the Virgin Islands have shown a steady increase from 67% in 1988 to an average of about 81% in 2014- a 1% increase in infants exclusively breastfed and a 2% increase infants breastfed last year. WIC was participating in the Pediatric Nutrition Surveillance System (PedNSS) but did not this year. There is a hope to resume participation in the Surveillance System.

The MCH program continued to support WIC breastfeeding outreach to ensure that the WIC Program continues to promote, support and protect breastfeeding among WIC participants as well as the MCH clinical population.

The WIC program has a lactation specialist that comes to the MCH post-partum clinics to provide education to our new Moms about the importance of breastfeeding. The MCH and WIC programs continue efforts to ensure mothers that breast milk alone is sustainable to babies for up to six months. WIC will also continue to provide support for breastfeeding mothers who work.

Moms are continually encouraged to breastfeed and are very comfortable breastfeeding in WIC clinic settings.

WIC participants continue to receive breastfeeding information and assistance that help to support breastfeeding efforts.

The hospitals in the territory are trending towards becoming "Baby friendly" hospitals in which the babies are rooming in with Mom and breastfeeding. The MCH program strongly supports this and will continue to work with the hospitals in this effort.

The MCH clinic in an effort to encourage Breastfeeding exclusively for 6 months has a lactation specialist come into the clinics during postpartum clinics to educate the Moms and provide support for the Moms in continuing to breastfeed.

As part of the strategy, educating business on the importance of breastfeeding for child growth and development is an initiative that the MCH program will embark upon to encourage the provision of breastfeeding/breast pumping rooms.

Additionally, the nurses have been counseling parents on safe sleep habits to reduce the risk of SIDS/SUIDS. The MCH program has procured a kiosk that will be stationed in the MCH clinics to provide education of various pediatric topics including safe sleep practices. The demos are user friendly and interactive and will provide important information to the MCH clients.

The MCH program has also procured tablets that have demos regarding safe sleep habits for the nurses to take out on Home Visits.

## Perinatal/Infant Health - Annual Report

### NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	85.0	90.0	95.0	98.0	100.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	85.0	90.0	95.0	98.0	100.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	60	65	70	75	80

Both the WIC program and the MCH program will increase breastfeeding among new mothers by providing direct support and counseling in both WIC and MCH Clinics.

The programs will maintain breastfeeding rates among new mothers by providing direct support and counseling in both WIC and MCH Clinics.

Maintain a breastfeeding environment within the WIC Program so that breastfeeding continues to be chosen as the preferred method of infant feeding by WIC mothers.

To promote, protect and support breastfeeding among WIC mothers.

Provide counseling, support and assistance to WIC moms with breastfeeding problems.

To implement the WIC Breastfeeding Peer Counselor Initiative.

To procure breast pumps and other breastfeeding aides for use in WIC clinics.

Provide WIC clients with adequate nutrition education to make informed, lifestyle change decisions, using effective

nutrition education interventions.

Additionally, The MCH program will continue to provide Safe sleep education through direct counseling as well as through the use of the Kiosk that provides interactive education via pictures and discussions.

The nurses in the MCH clinics will continue to screen Moms and counsel about safe sleep practices.

State Action Plan Table

Child Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
<p>Decrease the number of children with BMI &gt; 85%</p>	<p>Decrease the % of children between the ages of 2yrs to 17 yrs with a BMI &gt; 85% by 5% each year</p>	<p>Continue to partner and support WIC efforts in educating families on good nutrition</p> <hr/> <p>Continue to promote education within the community utilizing the WE CAN (Ways to Enhance Childhood Activity and Nutrition) program</p> <hr/> <p>Encourage discussions about proper nutrition and exercise with all MCH clients.</p> <hr/> <p>Utilize the Kiosk, DVDs, Educational materials within the MCH clinics to promote widespread education about the importance of exercise and proper nutrition</p>	<p>Percent of children in excellent or very good health</p> <hr/> <p>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</p>	<p>Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day</p>		

<p>Increase the percent of developmental screenings done in the territory</p>	<p>Increase the percent of children that receive developmental screenings during annual visit</p>	<p>Standardize the developmental screening that is done in the territory - ASQ testing</p> <hr/> <p>Ensure proper training of all staff</p> <hr/> <p>Collaborate with Infants and Toddler's program to ensure Early Intervention Services are provided for those that are found to have developmental delays</p> <hr/> <p>Continue to participate in DOH, DOE and Early Childhood outreaches to increase possibilities of screening</p>	<p>Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)</p> <hr/> <p>Percent of children in excellent or very good health</p>	<p>Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool</p>		
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**Child Health**

**Child Health - Plan for the Application Year**

I) Decrease the Number of children with BMI>85%.

The WIC program provides a comprehensive education on nutrition and physical activity. Both are very important to the overall health and well-being of the child.

WIC clients are certified and receive nutrition services according to established guidelines.

WIC program continues revision of policies and procedures so that they are compatible with WIC on the Web (WOW) functions and VENA.

Continue to train staff and implement changes necessary for the Value Enhanced Nutrition Assessment (VENA) requirements in order to continue to provide optimal nutrition services for WIC clients.

WIC Program staff will continue to provide participants education on basic nutrition and importance of physical activity.

WIC continues to provide specialized food packages based on individual needs.

WIC continues to provide food preparation classes for participants.

Implement a plan to address pediatric obesity prevention and management.

WIC participants will continue to receive nutrition assessment, counseling and education at certification. Nutrition education is provided individually and in interactive group sessions.

The WIC program will continue to encourage clients to participate in the Farmer's Program to increase the amount of fresh fruits and vegetables consumed in each child's diet.

The MCH program is a WE CAN (Ways to Enhance Childhood Activity and Nutrition) site. This is a national program that is geared towards educating parents and children in healthy nutritional and exercise habits to combat Obesity.

The MCH program will partner with the Department of Human Services and provide education to the parents of the Head Start Programs to ensure that parents get additional training and education of healthy habits. The MCH program will also partner with the Department of Education in their Parent University Program ( program for parents that educate parents on a variety of topics that improve their parenting skills). There is a parent educational component for the WE CAN program that has been taught to parents through Parent University in the past.

The MCH program also has a lot of brochures on healthy nutritional habits and will contribute to distribute these brochures to the clients in the MCH clinics, the FQHCs, schools and at outreach programs.

The MCH program just procured a kiosk that will be located in the MCH clinics that has specific programs geared towards educating children and their families about healthy nutrition in a fun and positive manner.

II) Developmental Screening:

Currently, the MCH program utilizes the Ages and Stages (ASQ) for hi-risk patients only in St. Thomas, but in St. Croix, the Denver Developmental Screening is utilized by not on a consistent basis. The goal is to identify children with developmental delays early and have a standardized screening method. The other challenge is that the program did not have the Spanish version; therefore many of the Spanish speaking patients had not been screened appropriately. Nevertheless, there is a Spanish version from the CDC that the program will begin to utilize such that all patients can be appropriately screened. The MCH program intends to standardize the screening by implementing the ASQ on both islands. All High-risk infants will be routinely screened by the nurses during the high- risk clinic visit. The screening will be done routinely as dictated by the screening schedule unless the infant/child is deemed developmentally appropriate by the Healthcare Provider. The MCH program also does Physical Exam Screening for the Head Start population and will return to routinely screening with the ASQ.

**Child Health - Annual Report**

**NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40	45	50	55	60

**NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	30	35	40	45	50

The WIC program continued implementation of the new food packages according to Federal Program Regulations which were designed to help fight the trend of increased obesity and chronic disease incidence in the nation. Additionally, the VI WIC program continued to partner with the Vi Department of Agriculture to continue the Farmer's Market Nutrition Program (FMNP). This program provides fresh, locally grown fruits and vegetables through farmer's markets to WIC participants in order to help improve their dietary choices and assist local farmers economically. Most of the year's activities focused around the continued incorporation the foods offered according to the Federal mandates/food guidelines of the WIC program and the FMNP.

Nutritionists continued to provide participant nutrition education materials to educate participants about proper dietary habits; about using more fruits and vegetables in their diets; and changing to reduced fat milk. WIC staff continued to help participants identify correct portion sizes through nutrition education hands on activities such as a session held in one clinic. Clients had to identify the standard serving size of 4 foods displayed. Client receive a prize if they got 3 out of 4 correct. This client centered approach embraces the new WIC Value Enhanced Nutrition Assessment (VENA) philosophy which focuses on desired health outcomes rather than deficiencies. It encourages the use of methods that are participant led. Additionally, clinic staff continue to provide nutrition education activities for WIC participants to assist them to prepare healthy meals for their families and also to keep them in good health. WIC participants receive nutrition education according to risk and program policies and procedures that would enable them to make informed decisions about their nutritional health.

State Action Plan Table

Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents.	<p>Increase access to comprehensive primary and preventive health care for adolescents ages 10-19 years.</p> <p>Continue outreach activities to parents and schools that encourage annual physical exams for this population.</p>	<p>Continue to promote education on wellness in adolescents to the community through outreach</p> <p>Continue outreach activities to parents and schools that encourage annual physical exams for this population.</p> <p>Partner with the schools and FQHCs to provide increase access to students for well child exams</p> <p>Partner with the Family Planning Program to go into the schools and provide a comprehensive adolescent program</p> <p>Partner with other agencies and Stakeholders to increase Community awareness</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p> <p>Percent of children with a mental/behavioral condition who receive treatment or counseling</p> <p>Percent of children in excellent or very good health</p> <p>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</p> <p>Percent of children 6 months through 17 years who are vaccinated annually against seasonal</p>	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

		<p>regarding the needs of the adolescent population</p> <hr/> <p>Develop a State Adolescent Health Care Plan</p>	<p>influenza</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p>			
<p>Decrease the number of teenage pregnancies</p>	<p>Increase access to comprehensive primary and preventive health care for adolescents ages 10-19 years.</p> <hr/> <p>Continue outreach activities to parents and schools that encourage annual physical exams for this population.</p> <hr/> <p>Decrease low birth weight</p>	<p>Continue to educate adolescents, families and parents about adolescent sexual health and the need for women's health</p> <hr/> <p>Educate on healthy sexual habits</p> <hr/> <p>Increase access to preconceptual care for the adolescent population ( male and female) by partnering with</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <hr/> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <hr/> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p> <hr/> <p>Percent of children with a mental/behavioral condition who receive treatment or counseling</p>	<p>Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.</p>		

	<p>Decrease infant mortality</p> <p>Decrease teenagers that are pregnant by 5%</p>	<p>the FQHC's</p>	<p>Percent of children in excellent or very good health</p> <p>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</p> <p>Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza</p> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p>		
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**Adolescent Health**

## Adolescent Health - Plan for the Application Year

Coordinate and implement activities with FQHC on St. Thomas addressing the adolescent population. Continue to support the FQHC on ST. Croix that has a school based program with resources and training. Continue outreach activities to parents and schools that encourage annual physical exams for this population. The Title V program will continue to collaborate with non-profit organizations to initiate school based health care programs to increase access to comprehensive, health care for adolescents. Continue to collaborate with Family Planning to increase adolescent access to gynecological services and pregnancy prevention measures. Continue to also collaborate with the Sexually Transmitted Disease (STD) program to increase screening for sexually transmitted diseases as well as to increase education and counseling of adolescents regarding sexually transmitted diseases. Continue to support Family Planning programs and collaborate to provide additional services. The MCH Program will be conducting an Adolescent Health Summit in August 2015 in collaboration with SAMSHA and Dr. Kreipe ( Professor/Director in Adolescent Health Medicine and Positive Youth Development to address adolescent mental health and utilizing a positive behavior approach for Adolescents. The Family Planning Program will continue to strive to increase awareness, especially to adolescents on choices and consequences as it relates to sexual involvement. Outreach staff will continue to provide sessions specifically for teens. Encourage adolescent male involvement in family planning outreach activities emphasizing shared responsibility and STD/HIV prevention.. The Family Planning Program will continue to provide access to comprehensive services, STD counseling and testing, with special counseling for adolescents. Outreach and community education efforts will continue to provide information through print, radio and TV media. Group sessions and other activities are being planned to promote wellness among the teen population. Increase access to teens at high risk for unintended pregnancies and STD through the Implementation of Satellite Teen Clinics on St. Thomas and St. Croix.

## Adolescent Health - Annual Report

### NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70	75	80	85	90

The expansion of access to primary care services especially to the adolescent population is limited due to lack of needed providers which hinders ability to provide primary care services at full capacity.

Lack of quality Adolescent Health Care programs is a national issue and one that affects the territory of the Virgin Islands as well.

There are a lot of risky behaviors that set up adolescents for academic failure, incompleteness of high school, diseases and illness. Many of these behaviors can be addressed by establishing a comprehensive adolescent health care program that the adolescents have access to.

The MCH program continued to provide access to primary care services, particularly for the uninsured and underinsured populations.

Activities to promote and increase access to preventive care included staff participation in health fairs at schools, community organizations etc. The MCH program continued to assess the immunization status of adolescents and promote the importance of maintaining up-to-date immunizations by assuring clients access to ongoing preventive care.

MCH Program Pediatrician and Home Visitation Nursing Supervisor provided education and information to adolescents on topics (age appropriate) such as delay in sexual activity; sexual coercion; abstinence; refusal skills; and protection against STDs and HIV/AIDS.

Sessions were held at public schools, juvenile centers, faith based organizations, and summer camps. Booklets designed to address various teen issues including sexual behavior, contraception, dating and healthy relationships were distributed to all adolescents that came to the MCH clinics as well as to the Family Planning Clinics, the FQHCs and various outreach programs conducted by the MCH program. All these programs and outreach efforts were designed to help teens make better reproductive choices such that the rate of teen pregnancy continues to decline and the health disparities as decline significantly.

The Family Planning program started conducting clinics in all of the public the high schools in the territory. They performed exams specifically geared towards reproductive health, counseling and contraceptive education. Students were encouraged to come to the clinic to obtain free contraception.

Currently, the Family Planning (FP) programs continued efforts to decrease teen births by providing confidential counseling, exams and contraceptive services within the High Schools in the territory. FP program staff continues to support teen pregnancy prevention activities by engaging adolescents through outreach activities that emphasize responsible decision making; education related to STD prevention and provision of clinical services. Staff continues providing education and outreach for clients aged 15-17 on reproductive health topics such as abstinence, decision making skills, healthy relationships, male responsibility, parent-child communication, safer sex, sexual responsibility, teen pregnancy issues and sexually-transmitted infections.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Increase the percentage of families that participate in transition planning	Increase the number of families for CSHCN that participate in the transition process by 5 %	<p>Utilize the GOT Transition model to promote family involvement in a structured manner</p> <p>Educate families on the importance of beginning the transition process by the age of 10 years</p> <p>Educate Health Care providers on the significance of transitioning families</p> <p>Participate with other Departments / Divisions in the transitioning process - Voc Rehab, DOE Special Ed, DHS, Community Service Providers, UVI, DD Council</p>	<p>Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system</p> <p>Percent of children in excellent or very good health</p>	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

**Children with Special Health Care Needs**  
**Children with Special Health Care Needs - Plan for the Application Year**

The GOT transition model is a very comprehensive model that allows for transitioning youth with Special Health Care Needs from the age of 9 years and incorporates parent and youth participation in the process; therefore, the MCH program will continue to utilize this model.

The MCH program plans to facilitate interagency collaboration to share resources and skills.

Use information received from the needs assessment to promote transition planning from pediatric to adult health care.

Continue to utilize, implement and evaluate transition planning health care plans for families of all children and adolescents with special health care needs.

Continue collaboration with other agencies and community-based partners to address health care transition issues.

Encourage adolescents and families to participate in transition planning and provide age appropriate transition services.

Establish data collection mechanism to monitor and track successful and effective transition.

Partner with Vocational Rehabilitation to promote job transitioning.

### Children with Special Health Care Needs - Annual Report

#### NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	35	40	45	50	55

The program utilized a plan for youth and adolescents with special health care needs transitioning to adulthood. The plan is based on the GOT Transition model which facilitates the integration of service systems to address the health issues of this population. Public health nurses ensured appropriate referrals for all adolescent and young adult clients to the appropriate agencies for health/school/work transition.

The plan supports skill-building opportunities for youth and their families. It supports their involvement as decision makers in their health care, education and employment.

There was some improvement in transition activities related to increasing family /youth advocacy and connecting families/youth with information regarding community / university resources for educational and vocational planning.

Collaboration and coordination continued with several agencies to assure effective transition - Departments of Education, Vocational Education; Department of Human Services, Vocational Rehabilitation; Department of Labor, Job Training and Placement; Community Health and 330 Centers; community based organizations, i.e. V.I. Resource Center for the Disabled, University of the Virgin Islands Center for Excellence on Developmental Disabilities, Virgin Islands Assistive Technology Foundation, Inc., Family Voices, V.I. Center for Independent Living, and V.I. Family Information Network on Disabilities.

Currently, transition planning with families is provided by public health nurses. Established transition planning checklists from the GOT Transition model are utilized. Additional training in GOT Transition Model as it continues to evolve will be provided to meet the needs of this population.

**State Action Plan Table**

**Cross-Cutting/Life Course**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Increase access to oral health care for the Maternal and Child population	<p>Increase access to oral health care for pregnant mothers by 2% annually</p> <p>Increase access to oral health care for children by 5%</p>	<p>Develop strategies to increase the number of Dental Providers in the territory</p> <p>Increase community awareness regarding the health risks of poor oral health during pregnancy and childhood</p> <p>Partner with FQHCs to provide training and increase education for Pediatric and Prenatal Health Care Providers</p>	<p>Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months</p> <p>Percent of children in excellent or very good health</p>	<p>A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year</p>		

**Cross-Cutting/Life Course**

**Cross-Cutting/Life Course - Plan for the Application Year**

The water supply in the Virgin Islands is not fluoridated. The use of sealants and fluoride has been proven to reduce or eliminate decay in the permanent teeth of children.

Partnership established with the pediatric dentist to assist the program in providing the spectrum of oral health services especially to the CSHCN population will be continued. This partnership is anticipated to address community needs related to oral health and provide education to students, families, child care providers and other professionals related to maintaining healthy teeth, prevention of tooth decay and proper nutrition.

In addition, they will provide improved increased access to dental services and expand sources of protective sealants.

Promote prevention activities related to oral health education targeting the general public in collaboration with the FQHCs.- possibly a Dental Health Day quarterly.

Training for physicians and other health care providers in oral health screening as part of routine health care will be

undertaken.

Develop and implement a data collection mechanism to assure the targeted population is receiving oral health services.

Promote oral prevention activities and health care for pregnant females

The MCH program is currently investigating the possibility of establishing a "Dentist without Borders" type system of health care.

Continue to educate parents on good oral habits for their children.

Promote and educate pregnant females on the importance of good oral health for both them and their babies.

### **Cross-Cutting/Life Course - Annual Report**

#### **NPM-13 A) Percent of women who had a dental visit during pregnancy**

<b>Annual Objectives</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective	25.0	30.0	35.0	40.0	45.0

#### **NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

<b>Annual Objectives</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective	70.0	75.0	80.0	85.0	90.0

Dental services are no longer available at clinics administered by the Department of Health. The two Federally Qualified Health Care Centers (FQHCs) are the only entities besides Private Dentists that are providing oral health care in the territory. Services include: examinations, fluoride applications, fillings and extractions. The Title V Program provided financial assistance for CSHCN requiring surgical or periodontal treatments who were not covered by the Medical Assistance Program or were uninsured.

Dental clinics continue to provide other oral health services, including assessment, oral examination, fluoride applications, restorative fillings and extractions. There is still no School Based Preventive Program since the resignation of the dentist in 2013. The MCH program is in the process of negotiating to have a group of Dentists come to the territory on a voluntary basis to fill in the major gaps in dental service.

### **Other Programmatic Activities**

Mental health undoubtedly remains an area of concern in the VI. MCH continues to work closely with the Division of Mental Health and Partners from the SAMHSA to develop and implement appropriate initiatives to address concerns and inadequacies in service and access for this population. One such initiative began in June 2014 as the MCH & CSHCN Program partnered with the Division of Mental Health, Alcoholism and Drug Dependency Services to convene a Learning Community for trauma informed care in collaboration with the Complex Trauma Treatment Network (CTTN). CTTN is a Category II NCTSN Center established in 2009 to develop, adapt and disseminate evidence-based practices (EBPs) for children and adolescents impacted by complex trauma. The CTTN provides intensive training and technical assistance to transform systems of care. Systemic change and dissemination of complex trauma assessment and treatment is facilitated through a learning community (LC) model in which service

providers 1) identify discrete working goals and 2) are supervised by complex trauma specialists over the course of a year in achieving their goals.

The regional Learning Communities are used to train communities of care in complex trauma assessment and intervention. Each Learning Community is composed of state- or multi-county-wide leadership and service providers from child protective services, juvenile justice, community health, foster and residential care, outpatient mental health, providers serving homeless and inner-city youth and consumer constituents. Each LC participates in a needs and readiness assessment, followed by a regional training on complex trauma.

A series of trainings were held to provide information on the impact of complex trauma on child development and the core principles of trauma informed systems change and served as the foundation for a year long initiative focused on implementation of trauma informed practices for children and families in the VI and PR region.

## **II.F.2 MCH Workforce Development and Capacity**

### **Title V Program Capacity**

The Department of Health's mission is to provide quality health care, regulate, monitor and enforce health standards to protect the public's health. This is achieved by openly communicating with the public, informing them of health care options, thus serving as a catalyst to assist them in making educated choices on receiving the highest quality of health care. As mandated by Virgin Islands Code, Titles 3 and 19, the Department of Health (DOH) has direct responsibility for conducting programs of preventive medicine. The agency is committed to building a sound policy and program infrastructure through employing providers and administrators from every aspect of health care. The Department is the sole state agency responsible for coordinating and providing a focal point for territory wide public health efforts on behalf of Virgin Islanders and visitors to the territory.[1]<sup>3</sup>

The three main facilities for primary care services are MCH & CSHCN Clinics, PHS 330-Community Health Centers, and hospital-based Community Health Clinics. On St. Thomas MCH's principal facility is located in the western district, the Community Health Clinics at the Roy L. Schneider Hospital serve the mid-island district, and the East End Health Center is located in the east district. On St. Croix, the Frederiksted Health Center is located in the western end of the island, and the MCH & CSHCN principal facility is located in the east at Charles Harwood Complex. On Cruz Bay, St. John, the Morris De Castro Clinic is the site for the MCH & CSHCN monthly Infant/Pediatric high-risk clinic.[1]

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[1] Title V Block Grant Annual Report 2009

## **II.F.3. Family Consumer Partnership**

### ***I. Partnerships, Collaborations, and Coordination***

The MCH & CSHCN Unit plays a leadership role in developing a comprehensive system of service. Agency and community resources include Human Services, Developmental and Disabilities Council, Department of Justice (Office for Paternity & Child Support), Department of Education, Special Education / Early Childhood Program, Head Start Program, and Disabilities and Rehabilitation Services. The V.I. Advocacy Agency, Inc., and Legal Services provide an effective voice for persons with disabilities. Representatives of these agencies serve on the MCH & CSHCN Advisory Council, V.I. Interagency Coordinating Council, and the V.I. Alliance for Primary Care, and

participate in planning and evaluating services for children with special health care needs.

Several government agencies, programs, foundations or community based organizations provide services to this vulnerable population comprised of women in their reproductive age, children and adolescents especially those with special health care needs. Appropriate coordination among all concerned agencies is vital in order to reduce duplication of effort and fragmentation of services, and to be more efficient in the use of limited resources. The VIDOH has established formal and informal relationships with other public agencies, academic institutions, and health care facilities. These relationships enhance the availability of comprehensive services for the MCH population. There are also memorandums of understanding among agencies and programs, which enhance coordination of services.

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

The Maternal, Infant, and Early Childhood Home Visiting Program has provided the US Virgin Islands (USVI) with the ability to service and collectively impact some of the Territory's most at risk families by supporting the implementation of evidenced based programs, providing needed jobs and capacity building in the field of early childhood.

### **States Supplemental Data Initiative (SSDI)**

The 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, including children and youth with special health care needs.

### **Early Hearing Detection and Intervention (EHDI)**

The primary emphasis of the project is to reduce the percent of infants lost to follow-up after missed initial screening or referral for repeat screening, and develop a tracking system to ensure they are rescreened and referred for timely diagnostic evaluation, treatment, and early intervention services.

### **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.

### **Infant and Toddlers Program**

The Infants and Toddlers Program supplements the Maternal Child Health and Children with Special Health Care Needs (MCH & CSHCN) Program, when public or private resources are otherwise unavailable, providing early intervention services such as: service coordination, physical and occupational therapy, speech and language pathology, vision therapy, special instruction, and family training.

### **Women, Infants and Children Program**

The VI WIC Program remains dedicated to provide family-centered nutrition education and services to WIC participants/caretakers in order that optimal growth and development of infants and children occur, and to assist in prenatal, postpartum and breastfeeding women making informed health and dietary choices for themselves and their families. An 86% partial breast-feeding rate among WIC post-partum participants was maintained. Exclusive breastfeeding rate is at 3%.

### **Family Planning Program**

The VI Family Planning Program seeks to ensure efficient and high quality reproductive health care services

including family planning as well as the related preventive and medical treatment that will improve the overall health of individuals. It facilitates access to health information to encourage healthy responsible behavior among at risk youth's age 10-21 years. VIFPP is a forerunner in the encouragement and empowerment of families through proactive involvement in healthy behavior and disease prevention. The program directly impacts more than 5,000 individuals while indirectly impacting 25,000 children, youth, parents, and community residents in the United States Virgin Islands.

### **Medicaid Program**

The VI Medicaid Program is the central source of health care for the Virgin Islands' most vulnerable residents: the aged, blind, disabled individuals and low income families who cannot afford to pay for their own health care needs. Eligibility is based on family income, available resources, and other factors. As the payer of last resort, the MCH & CSHCN Program is fiscally linked to the Medical Assistance Program. The Medical Assistance Program (MAP) functions under a congressionally imposed cap with a ratio of Federal and Local matching of 50/50. Mandatory Medicaid services include inpatient hospital, outpatient hospital, health clinic services, laboratory & x-ray services, Early & Periodic Screening, Diagnosis & Treatment (EPSDT), Family Planning, Nursing Home Services, Physician Services that must be pre-authorized, and Dental services. Optional services (but covered) include: optometrists, eyeglasses, prescribed drugs, air transportation, and respiratory therapy. Optional services (not covered) include: services in institutions for mental illness, hospital transfer/air ambulance transportation, dentures prosthetic devices, physical and occupational therapy, and/or durable equipment.

### **Role of the Parents**

Parents play a vital role in the program planning and evaluation, quantitatively, and qualitatively. Parents are involved in preliminary planning and implementation of each program. There are parent representatives on the MCH Advisory Council and the V.I. Interagency Coordinating Council. Here to Understand & Give Support (HUGS-VI) is a Parent Support Group for parents and caregivers of individuals with Special Needs. HUGS mission is to bring families and partners together to empower those with disabilities through learning, sharing, recreation and social events. HUGS-VI offers training programs about Special Education rights, and other programs that encourage those with disabilities to maximize their living potential. Parents also champion the Sickle Cell Associations in the Territory with ongoing monthly meetings.

### **V.I. Interagency Coordinating Council**

The V.I. Interagency Coordinating Council (VIICC) is charged with the task of advising and assisting the Department of Health in the implementation of the Individuals with Disabilities Education Act. The VIICC includes representatives of state public agencies, such as the Department of Health, MCH & CSHCN, Department of Human Services, Department of Education, Special Education/Early Childhood Education, University of the Virgin Islands, public and private providers, advocacy agencies, parents of children with disabilities, and the V.I. Legislature. An Interagency Memorandum of Understanding with the Departments of Health, Human Services, and Education coordinates the early intervention services for children under three years. This agreement is to be revisited to include children 0 – 5 years.

### **Early Childhood Advisory Committee**

Early Childhood Advisory Committee (ECAC): An interagency advisory committee established by the Office of the Governor to fulfill the mandates in the Improving Head Start for School Readiness Act to improve the lives of young children and their families. The purpose is to develop an agenda for improvements in child care and early childhood education that improves school readiness.

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

Established in October 1994 the Center was funded by the US Department of Health and Human Services, Administration on Developmental Disabilities and the US Department of Education, Office of National Institute on Disability and Rehabilitation Research.

The VIUCEDD 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 our special needs population. In 2014, their Annual Autism Conference featured Dr. Georgina Peacock, Medical Officer and Developmental-Behavioral Pediatrician, from the Centers for Disease Control and Prevention's National Center on Birth Defects and Developmental Disabilities.

### **Vocational Rehabilitation Program**

The Vocational Rehabilitation Program is authorized by the Rehabilitation Act of 1973, Public Law 93-112 and its amendments. The program is administered by the Department of Human Services. The program offers services 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.

### **Developmental Disabilities Council**

The Developmental Disabilities Program is authorized under Public Law 106-402, the Developmental Disabilities Assistance and Bill of Rights Act of 2000. The purpose of this act 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.

### **Office of Child Care & Regulatory Services**

The Department of Human Services, Office of Child Care & Regulatory Services, in collaboration with several partner agencies, works to improve the quality of child care in the territory and to ensure that quality child care is accessible to all families in the Virgin Islands. These goals 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. Using a sliding scale, eligibility is determined and subsidized child care is provided for the territory's eligible low income families through the voucher reimbursement program. This program serves infants to after school children from birth to age 13. Additionally, child care providers receive technical assistance and support to enhance and promote high quality early care and education in the territory.

## **II.F.4. Health Reform**

Health Reform:

The Governor convened a Health Reform Task Force to review these and other issues to decrease health disparities and increase access to care, particularly related to the ACA. After extensive research, the Task Force recommended that establishing a Health Insurance Exchange would be cost prohibitive and recommended that the Governor select the option of using the federal ACA funding to expand eligibility for Medicaid. MAP has 4 planned expansions: For the first expansion, begun in August, 2012, income eligibility limits were increased by \$1000/yr for pregnant women and children, increasing eligibility limit to \$6,500 plus \$1000 per family member. The second expansion being

carried out in August, 2014 uses SNAP income data to add over 3000 eligible but uninsured persons. The third expansion planned for the fall of 2014 will bring income limits up to 75% of Federal Poverty Level (FPL) for families and 100% of FPL for senior citizens and adults with disabilities. Additionally, former foster children 18-26 years of age will be added.

The fourth expansion was planned for late 2014 and added single childless adults to the Medicaid recipient rolls. 65 Medicaid recipients must utilize Department of Health Clinics, Frederiksted Health Center, or St. Thomas East End Medical Center as their good news to the extent health insurance becomes more affordable and available, it also exempts insurance companies from many of the ACA's market reform requirements, still to be clarified. Those who still cannot afford insurance and are still not their primary care medical homes. New to the program, medical homes are able to make direct referrals to specialists, who will be paid at the same rates as Medicare providers. This initiative is aimed at reducing the number of recipients who have to go off-island to receive care. The potential of adding additional low income children and pregnant women, as well as accessibility to specialists on-island, should create more opportunities for access to care for many. Very recent changes in interpretation of how the ACA requirements impact the territories may open the door for new insurance carriers to enter our market. While this eligible for Medicaid, even with the expanded eligibility requirements, may continue to have barriers to health care resources and services. Many uninsured individuals are generally unable to afford health insurance premiums, and; therefore, are not as likely to seek early prenatal or well-child care. Government programs, clinics and hospitals provide some access to health care services at little or no cost. Everyone, including low-income, uninsured or underinsured individuals and families have access to essential services, with most utilizing the hospital emergency rooms as primary care providers (ECAC Strategic Report 2014).

## **II.F.5. Emerging Issues**

### Health Insurance

Access to health services is limited with 28.7% of USVI residents' uninsured, and 24.3 % of children birth to five years uninsured. Individuals in the prime parenting age-group are uninsured at the rate of 53.4% of 18 to 24 year olds and 34.7% of 25 to 34 year olds.<sup>[1]</sup> This estimate is 7% higher than the uninsured rate for the entire US. Health Maintenance Organizations (HMOs) do not exist in the Virgin Islands. Medicaid managed care also does not exist in the territory. The Government of the Virgin Islands, as the largest employer, offers health insurance coverage to its employees. Health insurance fees and increased costs of government health insurance continue to be a barrier for low-income families.

The VI Bureau of Economic Research, Office of the Governor in the US Virgin Islands (USVI) contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health, to conduct the 2009 Virgin Islands Health Insurance Survey. The telephone survey was conducted to assess current rates and types of health insurance coverage among adults and children in the US Virgin Islands. The 2009 survey was comparable to a survey undertaken in 2003, allowing for some comparisons in rates over time. This study found that in 2009, approximately 28.7% (33,000) people were uninsured, up from 24.1% in 2003. This estimate is significantly higher than 7% higher than the rate for the entire US. 21% of the VI population was uninsured for the entire year. This is 9% higher than the equivalent measure for the entire US population.

Based on information collected in fiscal year 2009, an estimated 66% of children accessing services at the MCH program had Medical Assistance; 28% had no coverage and the remaining 6% had private or other group insurance. Any efforts to address elimination of health disparities in this population are severely hampered by stringent eligibility criteria of the Medical Assistance Program.

The poverty threshold for annual allowable income to qualify for Medicaid in the VI is \$9,500 for a family of five compared to the national average of \$23,497 (Census Bureau 2004) for a family of five. This 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 and therefore not as likely to seek early prenatal care which may contribute to poor birth outcomes. The actual cost of providing Medicaid services to this population who would otherwise meet eligibility criteria is unknown.

Economic changes have led to changes in health care insurance coverage. A 2012 study revealed a major drop in employer group insurance and an increase in coverage through public programs, such as Medicaid and Medicare. The number of uninsured increased from 28.7% to 29.7%, with 18.8% of children birth to five years uninsured. Individuals in the prime parenting age group are uninsured at rates of 39.4% for 18 to 24 year olds and 45.4% for 25 to 34 year olds (ECAC Strategic Report 2014).

### **Adolescent Health**

Health challenges continue to include obesity due to the combination of poor nutrition with low intake of readily available fruits and vegetables and low level of physical activity, even in many school settings. A large burden of asthma and diabetes are probably related to obesity, but deserve attention because on their own they can cause serious, and expensive, health risks. With respect to health risk behaviors, marijuana and alcohol use are much more concerning than tobacco. Sexual health risks for both STI and pregnancy are a concern because of the reported behaviors and were also recognized as topics that need to be addressed by youth themselves.

Teenage pregnancy and parenthood also continue to be major concerns threatening the development of teens and their children. Teen parents are more likely to lack sufficient developmental maturity and skills to consistently and adequately care for their children. Teen mothers are more likely to be unemployed. Children of teen parents are more likely to have health concerns, have behavior and learning problems, drop out of school before graduating, and become teen parents themselves – in a cycle that repeats the early childbirth risk. The rate of babies born to teens, ages 15 to 19, in the USVI is 43.1 births per thousand births, down from 51.3 births the previous year, representing a total of 164 births and representing 10% of the total live births and compared to 34 per thousand in the nation (ECAC Strategic Report, 2014).

In 2010, the Youth Risk Behavioral Survey was conducted in the St. Thomas/St. John District Public School District on behalf of the Virgin Islands Department of Education, office of State Office of Prevention, Intervention, Health and Wellness Program. 721 students participated from grades 6 through 12. Key findings from this survey are outlined in Attachment C. Of note, 38% of 6<sup>th</sup> and 7<sup>th</sup> grade respondents reported having more than one sip of beer, wine, or hard liquor and approximately 69% of those in grades 8 through 12 reported the same. A significant increase was also seen in sexual activity with 10% of respondents in grades 6 and 7 reported as having engaged in sex compared to 43% of those in grades 8 through 12 (Attachment 2).

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[1]Results from the 2009 Virgin Islands health Insurance Survey (January 2010).

### **II.F.6. Public Input**

#### **PUBLIC INPUT:**

The MCH Program continually receives public input throughout the year via Advisory Committee meetings and

through discussions with various partners at Stakeholders meetings. The VI DOH website contained information regarding the MCH program and allowed for public comments also. Surveys and the Needs Assessment also provided valuable input regarding our services and the needs of the community.

## II.F.7. Technical Assistance

### IV-F. TECHNICAL ASSISTANCE

Technical Assistance [Section 509 (a)(4)]

Technical assistance is of immeasurable value in ensuring the systematic, comprehensive, and valid public health approach to needs assessment, information systems development, general systems development, and special issues.

1. The request for technical assistance for survey sample analyses was selected because the program uses several surveys to address the needs of the MCH population including Family Needs Questionnaire, Provider and Client Satisfaction. Data analysis and reporting techniques are not familiar to all staff who could benefit from a training on survey analysis that would include topics such as: setup of data tables, using SPSS to analyze survey data, and preparing analyses and reports.
2. Augment the implementation of a comprehensive Adolescent Healthcare system through collaboration with national program with success and best practices history.  
Compose a representative team of at least 3 members of the MCH/CSHCN Advisory Board and program management to visit an accomplished MCH adolescent program. TA will help further the support for start-up of the VI adolescent service program. The intent is to conduct a demonstration (collaborative) program of six months to one year, in a select location, such a local high school where services will be administered in its entirety. TA will support the framework in which this endeavor will occur.

Overall, it is difficult to develop and implement a sound plan of action that involved access to integrated data on the population MCH/CSHCN serves. This is especially true because the vast majority of statistical data is managed by a broad field of inter and intra-agency sources, and there is formal infrastructure that guides access to State data. Therefore, we have no choice but to seek rapid, alternative measures to alleviate the hardship of acquiring that mandatory, vital information.

Through this request for TA, the VI MCH/CSHCN desire is to collaborate with other National program affiliates to share their methodology and to work through challenges.

### III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$ 1,492,742	\$ 1,492,742	\$ 1,444,717	\$ 1,444,717
<b>Unobligated Balance</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>State Funds</b>	\$ 1,376,753	\$ 1,376,753	\$ 0	\$ 0
<b>Local Funds</b>	\$ 0	\$ 0	\$ 1,205,253	\$ 938,753
<b>Other Funds</b>	\$ 0	\$ 0	\$ 171,500	\$ 171,500
<b>Program Funds</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>SubTotal</b>	\$ 2,869,495	\$ 2,869,495	\$ 2,821,470	\$ 2,554,970
<b>Other Federal Funds</b>	\$ 600,000	\$ 600,000	\$ 1,815,357	\$ 1,350,000
<b>Total</b>	\$ 3,469,495	\$ 3,469,495	\$ 4,636,827	\$ 3,904,970

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$ 1,475,616	\$ 1,397,359	\$ 1,452,192	\$
<b>Unobligated Balance</b>	\$ 0	\$ 0	\$ 0	\$
<b>State Funds</b>	\$ 0	\$ 0	\$ 0	\$
<b>Local Funds</b>	\$ 1,713,311	\$ 1,012,791	\$ 848,793	\$
<b>Other Funds</b>	\$ 171,500	\$ 171,500	\$ 335,498	\$
<b>Program Funds</b>	\$ 0	\$ 0	\$ 0	\$
<b>SubTotal</b>	\$ 3,360,427	\$ 2,581,650	\$ 2,636,483	\$
<b>Other Federal Funds</b>	\$ 1,311,777		\$ 1,350,000	\$
<b>Total</b>	\$ 4,672,204	\$ 2,581,650	\$ 3,986,483	\$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	\$ 1,464,800	\$
Unobligated Balance	\$ 0	\$
State Funds	\$ 848,793	\$
Local Funds	\$ 273,375	\$
Other Funds	\$ 62,123	\$
Program Funds	\$ 0	\$
SubTotal	\$ 2,649,091	\$
Other Federal Funds	\$ 1,345,374	\$
Total	\$ 3,994,465	\$

### III.A. Expenditures

#### V. BUDGET NARRATIVE

##### A. Expenditures

The request for federal funds is based on OBRA-89 regulations and program priorities. Emphasis is placed on allocating resources to ensure service availability, operational capacity, and the achievement of positive health outcomes. Specific allocations were made to support comprehensive program development and obtain needed personnel to implement the annual plan. This was done within restrictions of the Government of the Virgin Islands budgetary, financial, accounting, procurement, and personnel system. The MCH & CSHCN Program is guided by such government regulations and policies.

The budget for the Maternal Child Health Block Grant was developed by the Program Director and Federal Grants Manager. Specific estimates were requested of program staff responsible for implementing new initiatives. The process of deriving budget estimates was based on the previous fiscal year's actual expenditures and forecasted costs based on the program plan and proposed activities. Due to the assurance role of the MCH & CSHCN Program, funds must be kept available to cover patient care costs. The Title V guideline for the use of funds was adhered to. **(Please see Form 2, Form 3a & b)**. Estimates are used in providing budget and expenditure details, while using actual costs for direct services provision including personnel providing services to children with special needs and subspecialty contracts.

### III.B. Budget

#### Budget Narrative:

Federal funding through the Title V MCH Block Grant provides needed support to program efforts. Funding for State Systems Development Initiative is \$100,000 for FY 2012. An anticipated increase in the state match is budgeted to cover increases negotiated between the local government and employee unions. Local matching funds are used. The Virgin Islands Department of Health budget a total of \$2,649,091 for FY 2016. These funds are broken down as

follows:

	<u>Amount</u>	<u>Percent</u>
Federal Title V	\$1,464,800	55%
State	\$1,184,291	45 %

There is a 30/30/10 minimum funding requirement for federal funds. A waiver of this requirement is not requested during this budget year. Of the FY 2016 estimated Federal Title V allocation, the allocations are as follows:

Preventive and Primary Care for Children	\$439,400	(30%)
Children with Special Health Care Needs	\$439,440	(30%)
Title V Administrative Costs	\$146,480	(10%)

Local matching funds include an additional \$100,000 for the leasing of clinic space on St. Thomas. The MCH & CSHCN Program in the V.I. does not receive its program income for operating expenses. Clinic revenues are deposited into the Health Revolving Fund from which a portion is appropriated in the subsequent fiscal year. Funds will pay for personnel costs attributable to program administration for the federally budgeted positions of MCH & CSHCN Director and Assistant Director. These funds will also pay for inter-island travel, training, maintenance of office equipment, administrative office space, and utilities required for the appropriate administration of the program. Funds will be utilized to maintain clean and healthy facilities for all employees and consumers to enter and receive services.

Administrative costs up to 10 percent of the federal allocation will be used to support administrative staff salaries, newspaper announcements, travel for required meetings and conferences both inter-island and on the mainland, office and computer supplies, mailing, internet and postage and AMCHP annual membership dues.

The program does not anticipate any increase in Title V funding this fiscal year. With the anticipated reduction in local funds, the program will remain at or below the same funding levels of previous fiscal years. The program does not receive any funds from the indirect costs paid to the central government.

Program income from third party payors is not allocated back to the program for provision of services to children with special health care needs, expansion of family support and outreach services, or operating expenses. This income would enable the program's ability to plan activities that will address national and state performance measures outcomes.

### ***Direct and Enabling Services***

Title V funds will be used to provide preventive and primary care services to women of reproductive age and their infants up to one year of age, children, and youth. The scope of services includes prenatal and high-risk prenatal care, and postpartum care. These funds will be used to support: employment of required medical and clinic staff; needed services not directly being provided by the program including specialty consultation not available in the territory; equipment and supplies needed by the clinics; outreach activities, and technical assistance for developing a public awareness campaign. Funds will also be used to provide inter-island travel for the Territorial Perinatologist to visit St. Croix on a bi-weekly basis to provide clinical consultation and diagnostic studies such as sonograms and amniocentesis for high-risk prenatal clients.

Funds will be used for provision of services and / or care coordination for children with special health care needs. Clinic services include screening, diagnosis and treatment provided by the following disciplines: pediatrics, nursing, social work, nutrition, audiology, speech pathology, physical and occupational therapy. Funds will be used to support contractual costs to provide on-island specialty clinics in hematology, orthopedics, neurology, cardiology, and off-island services such as endocrinology consultations, and echocardiograms. The program will also pay for uninsured children with special health care needs who may need to travel to Puerto Rico for further medical care not available on island.

Funds are used to purchase hearing aids, audiology molds and supplies as required for children identified with permanent hearing loss up to 21 years of age.

***Public Health Services:***

Funds will be used to conduct public awareness and informational projects; to fund staff for outreach programs; public health awareness campaigns and health promotions activities. These activities include immunizations, oral health education, nutrition related activities and injury prevention.

Funds will be used to support the newborn hearing screening program primarily in the form of dedicated staff time to the project, and purchase of supplies required to perform screening.

Administrative costs for initial newborn metabolic/genetic screening is the responsibility of both hospitals. However, the Title V Program is responsible for follow-up and counseling for all children identified and diagnosed with an inheritable disorder.

Funds will be used to purchase vaccine not available through the Immunization Program for children whose families are insured and not eligible to receive vaccines through the VFC Program.

Funding to support the annual meeting of the MCH Advisory Council and MCH CQI team will be budgeted. Funds will be used to provide staff training and professional development necessary to ensure compliance with national performance measures. Funds will also be used for needs assessment and related activities.

Funds will also be used to provide technology for staff participation in web-casts and teleconferences related to program activities.

All travel expenses required to attend meetings, conferences and trainings in the mainland, and other related activities are paid with these funds.

Funds for the website development that is important not only for public education and information regarding MCH services, but also significant for training and information for staff development and building workforce capacity.

***Maintenance of State Effort***

The Virgin Islands Department of Health assures that the level of funding for the MCH & CSHCN Program will be maintained at a level at least equal to that provided during FY'89. Such funding will be provided through direct allocation of local funds and the provision of services to the MCH & CSHCN Program by other departmental programs as in-kind contributions. For FY 2011 funds used to support the leasing of space for the MCH Clinics in St. Thomas are not included to meet the maintenance of state level requirement.

***Fair Method of Allocating Funds***

A fair method for allocation of Title V funds throughout the Territory has been established by the State agency responsible for the administration of MCH & CSHCN Program. Allotment of Title V funds is based on the needs assessment and is calculated according to:

- Population size served and capacity of each island district; measurements of health status indicators and other data;
- Fixed personnel cost associated with maintaining direct service provision on each island in each of the three service components;
- Costs associated with maintaining support for services in all four levels of the pyramid;
- Coordination with other initiatives and funding streams which supplement, but do not supplant, Title V mandates.

***Targeting Funds of Mandated Title V Activities***

Funds from the Maternal and Child Health Services Block Grant will be used only to carry out the purpose of Title V programs and activities, consistent with Section 508.

***Reasonable Proportion of Funds for Section 501 Purposes***

A reasonable proportion of funds will be used to carry out the purposes described in Section 501 (a)(1)(A) through (D) of the Social Security Act. The MCH & CSHCN Program provides direct services in each of the related program components. All charges imposed for the provision of health services are pursuant to a public schedule of charges and adjusted to reflect the income, resources, and family size of individuals receiving the services. In determining ability to pay, a sliding fee scale is used based on the 2009 Federal Poverty Income Guidelines. Low income is defined as 200% of the federal poverty level or below.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [MCH & CSHCN 1995 Statement of Agreement.pdf](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [BG16 Appendices.pdf](#)

Supporting Document #02 - [MCH Org Chart 2015.pdf](#)

## VI. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: Virgin Islands**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>1. FEDERAL ALLOCATION</b>	\$ 1,464,800	\$ 1,397,359
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	\$ 439,440 (30%)	\$ 442,685 (31.7%)
B. Children with Special Health Care Needs	\$ 439,440 (30%)	\$ 489,076 (35%)
C. Title V Administrative Costs	\$ 146,480 (10%)	\$ 139,735 (10%)
<b>2. UNOBLIGATED BALANCE</b>	\$ 0	\$ 0
(Item 18b of SF-424)		
<b>3. STATE MCH FUNDS</b>	\$ 848,793	\$ 0
(Item 18c of SF-424)		
<b>4. LOCAL MCH FUNDS</b>	\$ 273,375	\$ 1,012,791
(Item 18d of SF-424)		
<b>5. OTHER FUNDS</b>	\$ 62,123	\$ 171,500
(Item 18e of SF-424)		
<b>6. PROGRAM INCOME</b>	\$ 0	\$ 0
(Item 18f of SF-424)		
<b>7. TOTAL STATE MATCH</b>	\$ 1,184,291	\$ 1,184,291
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	\$ 1,169,459	
<b>8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL</b>	\$ 2,649,091	\$ 2,581,650
(Same as item 18g of SF-424)		
<b>9. OTHER FEDERAL FUNDS</b>		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
<b>10. OTHER FEDERAL FUNDS</b>	\$ 1,345,374	
(Subtotal of all funds under item 9)		
<b>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</b>	\$ 3,994,465	\$ 2,581,650
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

**FY14 Annual Report Budgeted**

<b>1. FEDERAL ALLOCATION</b>	\$ 1,475,616
A. Preventive and Primary Care for Children	\$ 442,685
B. Children with Special Health Care Needs	\$ 885,370
C. Title V Administrative Costs	\$ 147,561
<b>2. UNOBLIGATED BALANCE</b>	\$ 0
<b>3. STATE MCH FUNDS</b>	\$ 0
<b>4. LOCAL MCH FUNDS</b>	\$ 1,713,311
<b>5. OTHER FUNDS</b>	\$ 171,500
<b>6. PROGRAM INCOME</b>	\$ 0
<b>7. TOTAL STATE MATCH</b>	\$ 1,884,811

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**FY16 Application  
Budgeted**

**9. OTHER FEDERAL FUNDS**

Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs;	\$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	\$ 1,000,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	\$ 95,374

**Form Notes For Form 2:**

The MCH Program incurred budget cuts to the General Fund by the Office of Management and Budgets as dictated by the Governor's proposed budget for the Department of Health and the approved Legislative budget such that the amount that was budgeted for local funds was reduced to \$1,012,791.00 instead of \$1,713,311.00 as was originally requested. The amount entered in the local funds 2014 Annual Report Expended reflects the sum of the State MCH and local MCH funds in the budgeted columns.

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, B. Children with Special Health Care Needs:</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The amount expended was less than what was budgeted because of Federal budget cuts and loss of specialty providers.
2.	<b>Field Name:</b>	<b>4. LOCAL MCH FUNDS</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The amount entered in the local funds 2014 Annual Report Expended reflects the sum of the State MCH and local MCH funds in the budgeted columns.
3.	<b>Field Name:</b>	<b>5. OTHER FUNDS</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	This funding source is from the VI DOH Community Health funding which is local funding that supports the financing of the clinics.

**Data Alerts:** None

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

**State: Virgin Islands**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>I. TYPES OF INDIVIDUALS SERVED</b>		
<b>IA. Federal MCH Block Grant</b>		
1. Pregnant Women	\$ 166,760	\$ 139,817
2. Infants < 1 year	\$ 172,760	\$ 120,300
3. Children 1-22 years	\$ 439,440	\$ 442,685
4. CSHCN	\$ 439,440	\$ 489,076
5. All Others	\$ 99,919	\$ 65,746
<b>Federal Total of Individuals Served</b>	<b>\$ 1,318,319</b>	<b>\$ 1,257,624</b>
<b>IB. Non Federal MCH Block Grant</b>		
1. Pregnant Women	\$ 200,850	\$ 252,033
2. Infants < 1 year	\$ 200,850	\$ 252,033
3. Children 1-22 years	\$ 355,300	\$ 336,042
4. CSHCN	\$ 355,300	\$ 316,840
5. All Others	\$ 71,991	\$ 27,343
<b>Non Federal Total of Individuals Served</b>	<b>\$ 1,184,291</b>	<b>\$ 1,184,291</b>
<b>Federal State MCH Block Grant Partnership Total</b>	<b>\$ 2,502,610</b>	<b>\$ 2,441,915</b>

**Form Notes For Form 3a:**

None

**Field Level Notes for Form 3a:**

1.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 4. CSHCN</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>

**Field Note:**

The amount expended was less than what was budgeted because of budget cuts experienced during the year and loss of specialists.

**Data Alerts:** None

**Form 3b**  
**Budget and Expenditure Details by Types of Services**

**State: Virgin Islands**

	FY16 Application Budgeted	FY14 Annual Report Expended
<b>II. TYPES OF SERVICES</b>		
<b>IIA. Federal MCH Block Grant</b>		
1. Direct Services	\$ 1,358,880	\$ 1,037,496
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 480,000	\$ 267,022
B. Preventive and Primary Care Services for Children	\$ 439,440	\$ 370,326
C. Services for CSHCN	\$ 439,440	\$ 400,148
2. Enabling Services	\$ 55,920	\$ 222,259
3. Public Health Services and Systems	\$ 50,000	\$ 137,604
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		\$ 1,200
Physician/Office Services		\$ 763,296
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 30,000
Dental Care (Does Not Include Orthodontic Services)		\$ 2,500
Durable Medical Equipment and Supplies		\$ 30,000
Laboratory Services		\$ 10,000
Other		
Patient off island travel for specialty services		\$ 5,500
Radiology Services		\$ 10,000
Case Manger and Social Worker Services		\$ 65,000
Allied Health Services (Speech, PT, Audiology)		\$ 120,000
Direct Services Total		\$ 1,037,496

**Federal Total**

\$ 1,464,800

\$ 1,397,359

**IIB. Non-Federal MCH Block Grant**

1. Direct Services	\$ 1,110,600	\$ 956,948
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 400,000	\$ 304,066
B. Preventive and Primary Care Services for Children	\$ 355,300	\$ 286,042
C. Services for CSHCN	\$ 355,300	\$ 366,840
2. Enabling Services	\$ 28,691	\$ 111,343
3. Public Health Services and Systems	\$ 45,000	\$ 116,000
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		
Physician/Office Services		\$ 675,535
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		\$ 72,000
Laboratory Services		\$ 53,413
Other		
Nursing Staff		\$ 156,000
Direct Services Total		\$ 956,948
<b>Non-Federal Total</b>	<b>\$ 1,184,291</b>	<b>\$ 1,184,291</b>

**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**

1,294

**1a. Core RUSP Conditions**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	1,294 (100.0%)	0	0	0 (0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	1,294 (100.0%)	0	0	0 (0%)
Methylmalonic acidemia (cobalamin disorders)	1,294 (100.0%)	0	0	0 (0%)
Isovaleric acidemia	1,294 (100.0%)	0	0	0 (0%)
3-Methylcrotonyl-CoA carboxylase deficiency	1,294 (100.0%)	0	0	0 (0%)
3-Hydroxy-3-methylglutaric aciduria	1,294 (100.0%)	0	0	0 (0%)
Glutaric acidemia type I	1,294 (100.0%)	0	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	1,294 (100.0%)	0	0	0 (0%)
Medium-chain acyl-CoA dehydrogenase deficiency	1,294 (100.0%)	0	0	0 (0%)
Very long-chain acyl-CoA dehydrogenase deficiency	1,294 (100.0%)	0	0	0 (0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	1,294 (100.0%)	0	0	0 (0%)
Trifunctional protein deficiency	1,294 (100.0%)	0	0	0 (0%)
Argininosuccinic aciduria	1,294 (100.0%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Citrullinemia, type I	1,294 (100.0%)	0	0	0 (0%)
Maple syrup urine disease	1,294 (100.0%)	0	0	0 (0%)
Homocystinuria	1,294 (100.0%)	0	0	0 (0%)
Classic phenylketonuria	1,294 (100.0%)	0	0	0 (0%)
Tyrosinemia, type I	1,294 (100.0%)	0	0	0 (0%)
Primary congenital hypothyroidism	1,294 (100.0%)	0	0	0 (0%)
Congenital adrenal hyperplasia	1,294 (100.0%)	4	0	0 (0%)
S,S disease (Sickle cell anemia)	1,294 (100.0%)	4	4	4 (100.0%)
S, β-thalassemia	1,294 (100.0%)	1	1	1 (100.0%)
S,C disease	1,294 (100.0%)	2	2	2 (100.0%)
Biotinidase deficiency	1,294 (100.0%)	0	0	0 (0%)
Cystic fibrosis	1,294 (100.0%)	8	0	0 (0%)
Hearing loss	1,294 (100.0%)	1	1	1 (100.0%)
Classic galactosemia	1,294 (100.0%)	0	0	0 (0%)

**1b. Secondary RUSP Conditions**

None

## 2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	1,029 (79.5%)	125	2	2 (100.0%)
G6PD deficiency	1,294 (100.0%)	71	71	37 (52.1%)

## 3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Headstart Hearing Screening	640	66	2	2

## 4. Long-Term Follow-Up

Infants with a confirmed diagnosis are counseled by the MCH nurses and/or the Pediatrician. The infants are placed in the hi-risk MCH clinics and are monitored carefully by the Pediatrician and are referred to the appropriate Pediatric Specialist. The infants are placed in the Infants and Toddlers Program as needed depending on the type of diagnosis. The infants are carefully monitored through case management. Hi-Risk clinic is for infants 0-12 months of age. If the infant after one year of age still has a condition that requires long-term care, they are transferred to Special Pediatrics Clinic in which the Pediatrician continues careful monitoring and developmental screening along with careful follow-up with Pediatric Specialists. Case management continues with these children to ensure that the needs of the child and family are met.

**Form Notes For Form 4:**

Communicable Disease Program conducts screening, counseling and follow up of clients with communicable diseases such as Tuberculosis, HIV, Gonorrhea, Chlamydia, Syphilis, Human Papilloma Virus.

**Field Level Notes for Form 4:**

None

**Form 5a**  
**Unduplicated Count of Individuals Served under Title V**

**State: Virgin Islands**

**Reporting Year 2014**

		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	113	60.0	0.0	8.0	30.0	2.0
2. Infants < 1 Year of Age	1,123	40.0	0.0	22.0	35.0	3.0
3. Children 1 to 22 Years of Age	1,695	47.0	0.0	7.0	45.0	1.0
4. Children with Special Health Care Needs	1,144	35.0	0.0	12.0	22.0	31.0
5. Others	257	50.0	0.0	10.0	35.0	5.0
<b>Total</b>	<b>4,332</b>					

**Form Notes For Form 5a:**

None

**Field Level Notes for Form 5a:**

None

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**  
**State: Virgin Islands**  
**Reporting Year 2014**

<b>Types Of Individuals Served</b>	<b>Total Served</b>
1. Pregnant Women	1,566
2. Infants < 1 Year of Age	1,294
3. Children 1 to 22 Years of Age	5,476
4. Children with Special Health Care Needs	1,133
5. Others	631
<b>Total</b>	<b>10,100</b>

**Form Notes For Form 5b:**

None

**Field Level Notes for Form 5b:**

None

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

**State: Virgin Islands**

**Reporting Year 2014**

**I. Unduplicated Count by Race**

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	1,294	86	928	0	0	0	0	280
Title V Served	1,123	22	899	0	0	0	0	202
Eligible for Title XIX	261	23	210	0	0	0	0	28
2. Total Infants in State	1,294	86	928	0	0	0	0	280
Title V Served	1,123	22	899	0	0	0	0	202
Eligible for Title XIX	261	23	210	0	0	0	0	28

**II. Unduplicated Count by Ethnicity**

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	858	156	280	1,294
Title V Served	775	146	202	1,123
Eligible for Title XIX	226	33	2	261
2. Total Infants in State	858	156	280	1,294
Title V Served	775	146	202	1,123
Eligible for Title XIX	226	33	2	261

**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**

	<b>Application Year 2016</b>	<b>Reporting Year 2014</b>
<b>A. State MCH Toll-Free Telephone Lines</b>		
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"	Marlene Ostalaza	Marlene Ostalaza
4. Contact Person's Telephone Number	(340) 776-3580	(340) 776-3580
5. Number of Calls Received on the State MCH "Hotline"		100
<b>B. Other Appropriate Methods</b>		
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	www.healthvi.org	www.healthvi.org
4. Number of Hits to the State Title V Program Website		50
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**

**Application Year 2016**

**1. Title V Maternal and Child Health (MCH)  
Director**

Name	Arlene Smith-Lockridge
Title	Dr.
Address 1	78-1-2-3 Estate Contant
Address 2	Elainco Bld, 3rd Fl
City / State / Zip Code	St. Thomas / VI / 00802
Telephone	(340) 776-1239
Email	arlene.smith-lockridge@doh.vi.gov

**2. Title V Children with Special Health Care  
Needs (CSHCN) Director**

Name	Arlene Smith-Lockridge
Title	Dr.
Address 1	78-1-2-3 Estate Contant
Address 2	Elainco bld, 3rd FL
City / State / Zip Code	St. Thomas / VI / 00802
Telephone	(340) 776-1239
Email	arlene.smith-lockridge@doh.vi.gov

**3. State Family or Youth Leader (Optional)**

Name
Title
Address 1
Address 2
City / State / Zip Code
Telephone
Email

**Form Notes For Form 8:**

None

**Form 9  
List of MCH Priority Needs**

**State: Virgin Islands**

**Application Year 2016**

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents.	Continued	
2.	Increase the percentage of families that participate in transition planning	Continued	
3.	Increase the number of women that have well women visits	New	
4.	Increase the number of women still breastfeeding until 6 months	New	
5.	Increase access to oral health care for the Maternal and Child population	New	
6.	Decrease the number of children with BMI > 85%	New	
7.	Increase the number of families educated on safe sleep practices	New	
8.	Increase the percent of developmental screenings done in the territory	New	
9.	Decrease the number of teenage pregnancies	New	

**Form Notes For Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 10a  
National Outcome Measures (NOMs)**

**State: Virgin Islands**

**Form Notes for Form 10a NPMs and NOMs:**

NPM#1: Based on data from the FQHCs and the Family Planning Clinics, 4,427 females between the ages of 12 yrs and 64 yrs had a well woman visit that also included PAP smears, breast exam and STD screening. The VI Community Survey data reveals that there are 42,318 females between the ages of 10yrs and 64 yrs in the territory. This means that only approximately 6% of this population had a well woman visit. This number does not include private physicians. NPM #4: Based on WIC data, of the 709 mothers enrolled in the program, 573 (80%) ever breastfed. It is not clear whether these 573 were still breastfeeding at 6 months. NPM # 13: Based on data obtained from the FQHC it is estimated that 27% of pregnant females had a oral exam during pregnancy. (150 pregnant mothers out of 1294 births)

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

**FAD Not Available for this measure.**

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	60.7
<b>Numerator</b>	785
<b>Denominator</b>	1,294
<b>Data Source</b>	Nursery and Labor and Delivery Statistics for both hospitals in the territory (Juan Luis Hopspital on St. Croix and Roy L. Schnieder Hospital in St. Thomas)
<b>Data Source Year</b>	2014

**NOM-1 Notes:**

Data was obtained from the Nurseries at the two hospitals in the territory: Schneider Regional Medical Center in St. Thomas and Juan F. Luis Hospital in St. Croix. The numerator reflects the number of women that stated that they began prenatal care in the first trimester and the denominator reflects the total number of births in the territory.

**Data Alerts:** None

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

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	595.1
Numerator	77
Denominator	1,294
Data Source	Nursery and Labor and Delivery Stats from both hospitals in the territory ( Juan Luis Hospital in st. Croix and Roy L. Schneider in St. Thomas)
Data Source Year	2014

**NOM-2 Notes:**

Data was obtained from the Nurseries at the two hospitals in the territory: Schneider Regional Medical Center in St. Thomas and Juan F. Luis Hospital in St. Croix. The numerator reflects the number of women giving birth in the hospitals that had morbidity related issues such as Pregnancy Induced Hypertension, Gestational Diabetes, HELLP syndrome, severe Pre-eclampsia, Intra-uterine growth retardation. The denominator reflects the total number of births in the territory.

**Data Alerts:** None

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

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	77.3
Numerator	1
Denominator	1,294
Data Source	Nurseries in both hospitals in the territory
Data Source Year	2014

**NOM-3 Notes:**

Data was obtained from the Nurseries at the two hospitals in the territory: Schneider Regional Medical Center in St. Thomas and Juan F. Luis Hospital in St. Croix. The numerator reflects the number of women that stated that they began prenatal care in the first trimester and the denominator reflects the total number of births in the territory.

**Data Alerts:** None

**NOM-4.1 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
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	7.0
<b>Numerator</b>	91
<b>Denominator</b>	1,294
<b>Data Source</b>	VI Bureau of Health Statistics
<b>Data Source Year</b>	2014

**NOM-4.1 Notes:**

All data was obtained from the VI Bureau of Statistics from 2014.

**Data Alerts:** None

**NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	1.7 %	0.4 %	24	1,386
2011	2.6 %	0.4 %	38	1,463
2010	1.7 %	0.3 %	27	1,570
2009	1.3 %	0.3 %	21	1,670

**Legends:**

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	1.9
<b>Numerator</b>	25
<b>Denominator</b>	1,294
<b>Data Source</b>	VI Bureau of Health Information
<b>Data Source Year</b>	2014

**NOM-4.2 Notes:**

The information provided is from the VI Bureau of Health Information and Statistics.

**Data Alerts:** None

**NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	7.9 %	0.7 %	109	1,386
2011	7.8 %	0.7 %	114	1,463
2010	7.3 %	0.7 %	114	1,570
2009	8.3 %	0.7 %	138	1,670

**Legends:**

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	5.1
<b>Numerator</b>	66
<b>Denominator</b>	1,294
<b>Data Source</b>	VI Bureau of Health Information and Statistics
<b>Data Source Year</b>	2014

**NOM-4.3 Notes:**

The information provided was obtained from the VI Bureau of Health Information and Statistics for 2014.

**Data Alerts:** None

**NOM-5.1 Percent of preterm births (<37 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	2.9
<b>Numerator</b>	37
<b>Denominator</b>	1,294
<b>Data Source</b>	VI Bureau of Health Information and Statistics
<b>Data Source Year</b>	2014

**NOM-5.1 Notes:**

None

**Data Alerts:** None

**NOM-5.2 Percent of early preterm births (<34 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	3.8 %	0.5 %	52	1,359
2011	4.0 %	0.5 %	58	1,442
2010	2.6 %	0.4 %	40	1,560
2009	2.3 %	0.4 %	38	1,663

**Legends:**

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	2.7
<b>Numerator</b>	35
<b>Denominator</b>	1,294
<b>Data Source</b>	VI Bureau of Health Information and Statistics
<b>Data Source Year</b>	2014

**NOM-5.2 Notes:**

All data provided is from the VI Bureau of Health Information and Statistics from 2014.

**Data Alerts:** None

**NOM-5.3 Percent of late preterm births (34-36 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	8.8 %	0.8 %	120	1,359
2011	7.5 %	0.7 %	108	1,442
2010	8.1 %	0.7 %	127	1,560
2009	7.6 %	0.7 %	127	1,663

**Legends:**

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	6.6
<b>Numerator</b>	86
<b>Denominator</b>	1,294
<b>Data Source</b>	VI Bureau of Health Information and Statistics
<b>Data Source Year</b>	2014

**NOM-5.3 Notes:**

All the information provided is from the VI Bureau of Health Information and Statistics from 2014.

**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
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	30.5
<b>Numerator</b>	395
<b>Denominator</b>	1,294
<b>Data Source</b>	VI Bureau of Health Information and Statistics
<b>Data Source Year</b>	2014

**NOM-6 Notes:**

The information provided was from the VI Bureau of Health Information and Statistics

**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
2013/Q2-2014/Q1	6.0 %			

**Legends:**  
🚩 Indicator results were based on a shorter time period than required for reporting

**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
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
2012	8.5 ⚡	2.5 % ⚡	12 ⚡	1,415 ⚡
2011	8.1 ⚡	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
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
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 Sleep-related 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
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 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	0.1
Numerator	1
Denominator	1,294
Data Source	Nursery Data from Juan Luis Hospital and Schneider Regional Medical Center
Data Source Year	2014

**NOM-10 Notes:**

The data provided is from the Nurseries from both hospitals ( Juan Luis Hospital and Schneider Regional Medical Center) for 2014.

**Data Alerts:** None

**NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**

**FAD Not Available for this measure.**

**NOM-11 Notes:**

None

**Data Alerts:** None

**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)**

**FAD Not Available for this measure.**

**NOM-12 Notes:**

None

**Data Alerts:** None

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

**FAD Not Available for this measure.**

**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 12 months**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	15.6 %	0.9 %	3,983	25,565

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width >20% 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
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
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
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

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	0.0
<b>Numerator</b>	0
<b>Denominator</b>	5,798
<b>Data Source</b>	VI Office of Highway Safety
<b>Data Source Year</b>	2014

**NOM-16.2 Notes:**

The VI Office of Highway Safety reported that there were no fatalities due to Motor Vehicle Accidents. in 2014. The denominator is based on VI Community Survey 2012 population

**Data Alerts:**

1.	A value of zero has been entered for the numerator in NOM #16.2. Please review your data to ensure this is correct.
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**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
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

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	17.2
<b>Numerator</b>	1
<b>Denominator</b>	5,798
<b>Data Source</b>	VI Bureau of Health Information and Statistics
<b>Data Source Year</b>	2014

**NOM-16.3 Notes:**

the VI Bureau of Health Statistics reported 1 suicide which reflects the numerator. the denominator represents the number of children between 15-19 yrs as reported by the VI Census Survey of 2012.

**Data Alerts:** None

**NOM-17.1 Percent of children with special health care needs**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	9.8 %	0.7 %	2,642	26,958

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system**

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	9.4 %	2.8 %	181	1,924

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM-17.2 Notes:**

None

**Data Alerts:** None

**NOM-17.3 Percent of children diagnosed with an autism spectrum disorder**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	0.9 %	0.2 %	200	23,044

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM-17.3 Notes:**

None

**Data Alerts:** None

**NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.9 %	0.3 %	440	23,012

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM-17.4 Notes:**

None

**Data Alerts:** None

**NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	24.9 %	5.1 %	226	909

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM-18 Notes:**

None

**Data Alerts:** None

**NOM-19 Percent of children in excellent or very good health**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	81.5 %	0.9 %	21,937	26,933

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM-19 Notes:**

None

**Data Alerts:** None

**NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	39.5 %	1.6 %	4,538	11,491

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	23.4 %	0.9 %	502	2,147

**Legends:**  
 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: Youth Risk Behavior Surveillance System (YRBSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
<b>Legends:</b>  Indicator has an unweighted denominator <100 and is not reportable  Indicator has a confidence interval width >20% and should be interpreted with caution				

**NOM-20 Notes:**

None

**Data Alerts:** None

**NOM-21 Percent of children without health insurance**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	28.7
Numerator	7,616
Denominator	26,545
Data Source	2012 VI Community Survey
Data Source Year	2012

**NOM-21 Notes:**

All data was reported from 2014 VI Community Survey.

**Data Alerts:** None

**NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	37.5 %	4.3 %	874	2,332
2012	41.5 %	3.9 %	1,070	2,577
2011	41.9 %	3.0 %	1,025	2,446
2010	37.1 %	4.1 %	916	2,472
2009	30.9 %	3.4 %	885	2,864

**Legends:**  
 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6  
 Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	
<b>Numerator</b>	
<b>Denominator</b>	
<b>Data Source</b>	2013
<b>Data Source Year</b>	National Immunization Survey

**NOM-22.1 Notes:**

None

**Data Alerts:** None

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

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	7.0
Numerator	117
Denominator	1,660
Data Source	MCH Clinics
Data Source Year	2014

**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) - Female

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	33.2 %	4.4 %	1,142	3,440
2012	28.8 %	3.3 %	1,056	3,673
2011	26.4 %	3.4 %	1,030	3,909
2010	22.5 %	4.7 %	1,037	4,614
2009	14.9 %	3.2 %	753	5,059

**Legends:**  
 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6  
 Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	17.2 %	3.4 %	683	3,980
2012	10.5 %	2.3 %	400	3,826
2011	NR 	NR 	NR 	NR 

**Legends:**  
 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6  
 Estimates with 95% confidence interval half-widths > 10 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)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM-22.5 Notes:**

None

**Data Alerts:** None

**Form 10a**  
**National Performance Measures (NPMs)**

**State: Virgin Islands**

**NPM-1 Percent of women with a past year preventive medical visit**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.0	35.0	40.0	45.0	50.0

**NPM-4 A) Percent of infants who are ever breastfed**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	85.0	90.0	95.0	98.0	100.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	85.0	90.0	95.0	98.0	100.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	60.0	65.0	70.0	75.0	80.0

**NPM-6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	45.0	50.0	55.0	60.0

**NPM-8 Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	30.0	35.0	40.0	45.0	50.0

**NPM-10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	75.0	80.0	85.0	90.0

**NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	35.0	40.0	45.0	50.0	55.0

**NPM-13 A) Percent of women who had a dental visit during pregnancy**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.0	30.0	35.0	40.0	45.0

**NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	75.0	80.0	85.0	90.0

**Form 10b**  
**State Performance/Outcome Measure Detail Sheet**  
**State: Virgin Islands**

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10c**  
**Evidence-Based or Informed Strategy Measure Detail Sheet**  
**State: Virgin Islands**

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10d**  
**National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**

**State: Virgin Islands**

**Form Notes for Form 10d NPMs and SPMs**

Denominator is based on the VI Community Survey. The numerator is based on data from the two hospitals in the territory and the Office of Highway Safety Statistics for 2014

**NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.**

	2011	2012	2013	2014	2015
Annual Objective	95.0	95.0	95.0	90.0	95.0
Annual Indicator	53.1	89.9	71.6	65.6	
Numerator	85	250	159	166	
Denominator	160	278	222	253	
Data Source	NBS Program	NBS Program	NBS Program	NBS Program	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	The nurses worked diligently to follow up patients but patients could not be found because of inaccurate information regarding telephone numbers and addresses. Letters were sent out to the addresses received on the Newborn Genetic Screening results but several were returned to sender (MCH Program) because addressee could not be located. The program continues to search for families up to 1 year.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Denominator for 2013 reflects initial positives for for expanded screening - total 50 disorders. This includes G6PD- 81; Sickle cell disease -3; Sickle cell trait - 108
3.	<b>Field Name:</b>	<b>2012</b>

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**Field Note:**

Denominator for 2012 reflects initial positives for for expanded screening - total 50 disorders. This includes G6PD- 87; Sickle cell disease -6; Sickle cell trait - 170.

Numerator for 2012 reflects rescreening, final diagnosis, counseling and/ or enrollment in appropriate treatment for identified disorder.

All presumptive or initial positives are confirmed by DNA analysis.

4. **Field Name:** 2011

**Field Note:**

Denominator for 2011 reflect s initial positives for for expanded screening - total 50 disorders. This includes G6PD- 52; Sickle cell disease -4; Sickle cell trait - FAS -45 / FAC-20, FAV-3, FA+Barts -19, FAS+Hgb Bart-1.

Numerator for 2011 reflects rescreening, final diagnosis, counseling and/ or enrollment in appropriate treatment for identified disorder.

All presumptive or initial positives are confirmed by DNA analysis.

All data obtained from the Newborn Screening Database

**Data Alerts:** None

**NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)**

	2011	2012	2013	2014	2015
Annual Objective	40.0	40.0	45.0	50.0	50.0
Annual Indicator	32.0	35.0	39.0	42.4	
Numerator	351	486	400	365	
Denominator	1,098	1,389	1,026	860	
Data Source	Client Satisfaction Survey	Client Satisfaction Survey	Client Satisfaction	Client Satisfaction	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Denominator is # children with special needs receiving services during reporting year at MCH program clinics.

Numerator is # obtained from client satisfaction surveys given throughout the reporting year and 2010 needs assessment.

The VI is not included in the CSHCN Survey and therefore, a modified version is used to produce a client satisfaction survey.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Denominator is # children with special needs receiving services during reporting year at MCH program clinics.

Numerator is # obtained from client satisfaction surveys given throughout the reporting year and 2010 needs assessment.

The VI is not included in the CSHCN Survey and therefore, a modified version is used to produce a client satisfaction survey.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Denominator is # children with special needs receiving services during reporting year at MCH program clinics.

Numerator is # obtained from client satisfaction surveys given throughout the reporting year and 2010 needs assessment.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Denominator is # children with special needs receiving services during reporting year at MCH program clinics.

Numerator is # obtained from client satisfaction surveys given throughout the reporting year and 2010 needs assessment.

**Data Alerts:** None

**NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	60.0	60.0	50.0	60.0	65.0
Annual Indicator	30.0	32.0	39.0	57.6	
Numerator	329	444	400	495	
Denominator	1,098	1,389	1,026	860	
Data Source	Health Pro Database System/MCH	MCH & CSHCN Program	MCH & CSHCN Program	MCH & CSHCN Program	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
<p><b>Field Note:</b>            More than half of all CSHCN with high complexity diagnoses receive care coordination services at MCH clinics in both districts.            These services meet the requirements of the medical home model as defined by the American Academy of Pediatrics as “a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.”</p> <p>TheVI is not included in the CSHCN Survey, therefore a client satisfaction survey that is a modified version is used to obtain data.</p> <p>Denominator obtained from MCH clinics monthly reports.</p> <p>Numerator reflects the estimated number of children requiring care/service coordination by public health physicians and nurses, and are considered to have complex medical diagnoses; require home visits, IEP's, and multi-specialty services.</p>		
2.	<b>Field Name:</b>	<b>2013</b>

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**Field Note:**

More than half of all CSHCN with high complexity diagnoses receive care coordination services at MCH clinics in both districts.

These services meet the requirements of the medical home model as defined by the American Academy of Pediatrics as “a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The VI is not included in the CSHCN Survey, therefore a client satisfaction survey that is a modified version is used to obtain data.

Denominator obtained from MCH clinics monthly reports.

Numerator reflects the estimated number of children requiring care/service coordination by public health physicians and nurses, and are considered to have complex medical diagnoses; require home visits, IEP's, and multi-specialty services.

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3. **Field Name:** 2012

**Field Note:**

More than half of all CSHCN with high complexity diagnoses receive care coordination services at MCH clinics in both districts.

These services meet the requirements of the medical home model as defined by the American Academy of Pediatrics as “a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Denominator obtained from MCH clinics monthly reports.

Numerator reflects the estimated number of children requiring care/service coordination by public health physicians and nurses, and are considered to have complex medical diagnoses; require home visits, IEP's, and multi-specialty services.

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4. **Field Name:** 2011

**Field Note:**

More than half of all CSHCN with high complexity diagnoses receive care coordination services at MCH clinics in both districts.

These services meet the requirements of the medical home model as defined by the American Academy of Pediatrics as “a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Denominator obtained from MCH clinics monthly reports.

Numerator reflects the estimated number of children requiring care/service coordination by public health physicians and nurses, and are considered to have complex medical diagnoses; require home visits, IEP's, and multi-specialty services.

**Data Alerts:** None

**NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	60.0	60.0	65.0
Annual Indicator	50.0	52.0	31.0	37.9	
Numerator	549	722	318	326	
Denominator	1,098	1,389	1,026	860	
Data Source	HealthPro database/MCH	MCH Program	MCH Program	MCH Program	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
 Numerator reflects the number of CSHCN enrolled in the MCH program that have adequate private and public insurance on the survey.  
  
 The denominator reflects the number of CSHCN enrolled in the MCH program.  
  
 The VI is not included in the CSHCN Survey and therefore bases the information on data collected in the clinics.
- Field Name:** 2013

**Field Note:**  
 Numerator reflects the number of CSHCN enrolled in the MCH program that have adequate private and public insurance on the survey.  
  
 The denominator reflects the number of CSHCN enrolled in the MCH program.  
  
 The VI is not included in the CSHCN Survey and therefore bases the information on data collected in the clinics.
- Field Name:** 2012

**Field Note:**  
 Numerator reflects the number of CSHCN enrolled in the MCH program that have adequate private and public insurance on the survey.  
 The denominator reflects the number of CSHCN enrolled in the program.
- Field Name:** 2011

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**Field Note:**

Numerator obtained from MCH clinics via Health Pro database in both districts reflecting families reporting a source of insurance including Medicaid.

Denominator obtained from MCH clinics monthly reports of CSHCN.

**Data Alerts:** None

**NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	40.0	40.0	40.0	40.0	40.0
Annual Indicator	20.0	21.0	25.0	33.1	
Numerator	220	292	257	285	
Denominator	1,098	1,389	1,026	860	
Data Source	MCH Program/CSHCN Survey	MCH & CSHCN Program	MCH & CSHCN programs	MCH & CSHCN programs	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Data is from the MCH & CSHCN Program. The denominator reflects the total number of CSHCN population served by MCH clinics The numerator represents the number that stated that the service system was organized. The VI is not included in the CSHCN Survey and therefore a modified version was created and given out as a client satisfaction survey.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Data is from the MCH & CSHCN Program.  
The denominator reflects the total number of CSHCN population served by MCH clinics  
The numerator represents the number that stated that the service system was organized.

The VI is not included in the CSHCN Survey and therefore a modified version was created and given out as a client satisfaction survey.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Numerator: number reflects the responses of families in the CSHCN Survey for reporting year.

Denominator: the number of children with CSHCN attending MCH clinics in both districts.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Numerator: number reflects the responses of families in the CSHCN Survey for reporting year.

Denominator: the number of children with CSHCN attending MCH clinics in both districts.

Data Alerts: None

**NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.**

	2011	2012	2013	2014	2015
Annual Objective	10.0	15.0	20.0	20.0	20.0
Annual Indicator	2.6	8.2	29.1	29.1	
Numerator	20	50	100	100	
Denominator	784	610	344	344	
Data Source	MCH Program	MCH & CSHCN Program	MCH & CSHCN Program	MCH & CSHCN Program	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Numerator: The number of youth ages 11-18 years with special health care needs within the MCH clinics that received services necessary to transition to all aspects of life.

Denominator: The total number of children with special health care needs ages 11-18 enrolled and receiving services within the MCH clinics.

Transition services begin at age 11 years in the MCH clinics utilizing GOT Transition model.

2.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Numerator: The number of youth ages 11-18 years with special health care needs within the MCH clinics that received services necessary to transition to all aspects of life.

Denominator: The total number of children with special health care needs ages 11-18 enrolled and receiving services within the MCH clinics.

Transition services begin at age 11 years in the MCH clinics.

**Data Alerts:** None

**NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.**

	2011	2012	2013	2014	2015
Annual Objective	75.0	75.0	100.0	65.0	75.0
Annual Indicator	80.6	92.8	58.5	39.8	
Numerator	482	1,079	595		
Denominator	598	1,163	1,017		
Data Source	MCH Program	MCH & FQHC Clinics	MCH & FQHC	National Immunization Survey	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	The 2013 National Immunization Survey reported a 39.8% immunization rate for this population in the territory. This number is decreased from the 2012 data that reflected a 49.9% immunization rate.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	The denominator represents the number of children 19-25 months of age that presented to the MCH and the FQHC clinics between Jan 2013 and Dec 2013.  The numerator is the number of children that completed the immunization series for age according to the MCH and the FQHC clinics.  The 2012 National Immunization Survey reported a 49.9 +/- immunization rate for this population in the territory. This number is slightly decreased from the 2011 data that reflected a 51% immunization rate.
3.	<b>Field Name:</b>	<b>2012</b>

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**Field Note:**

Denominator is # of children 19-35 months old born between January 2009 and July 2011.

Numerator is of # complete for age according to the MCH Program and the 330 Federally Qualified Health Care Centers. This report reflects all children 19-35 months old attending these clinics whose immunization status is complete.

The 2010 National Immunization Survey (NIS) reports a 43.7% immunization rate for the Virgin Islands. The estimates are based on children born January 2007 through July 2009. The percentage reflects coverage for 4:3:1:3:3:1:4 vaccine series that includes the full Hib series. (4 DTap:3 Polio:1MMR:3 Full HIB: 3Hep B:1 Varicella:4PCV. The NIS reports 45.6% that is the series without the full HIB series. MCH data reflects the full HIB series

4.

**Field Name:**

**2011**

**Field Note:**

Denominator is # of children 19-35 months old born between January 2006 and July 2008.

Numerator is of # complete for age according to the National Immunization Survey for 2009. This reports reflects all children 19-35 months old in the territory whose immunization status is reported to the program.

The 2010 National Immunization Survey (NIS) reports a 43.7% immunization rate for the Virgin Islands. The estimates are based on children born January 2007 through July 2009. The percentage reflects coverage for 4:3:1:3:3:1:4 vaccine series that includes the full Hib series. (4 DTap:3 Polio:1MMR:3 Full HIB: 3Hep B:1 Varicella:4PCV. The NIS reports 45.6% that is the series without the full HIB series. MCH data reflects the full HIB series.

**Data Alerts:** None

**NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.**

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	5.0	5.0	2.0
Annual Indicator	17.1	5.0	9.8	6.9	
Numerator	72	38	48	40	
Denominator	4,213	7,563	4,892	5,798	
Data Source	Hospital Data	Hospital data	Hospital data	Hospital data	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Population data for 15-17 year females is not reported as a separate category in the VI 2012 Census. Category is for 15-19 year old for 2012 VI Census. Denominator is an overestimation of the number of 15 -17 year old females in the territory. Numerator for this reporting year is from data provided by the only 2 hospitals within the territory - Schneider Regional Medical Hospital ( St. Thomas) and Juan Luis Medical Center ( St. Croix).
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Population data for 15-17 year females is not reported as a separate category in the VI 2010 Census. Category is for 15-19 year old for 2010 VI Census. Denominator is an overestimation of the number of 15 -17 year old females in the territory.  Numerator for this reporting year is from data provided by the only 2 hospitals within the territory - Schneider Regional Medical Hospital ( St. Thomas) and Juan Luis Medical Center ( St. Croix).
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Population data for 15-17 year females is not reported as a separate category in the VI 2010 Census. Category is for 15-19 year olds for 2010 VI Census. Denominator is an overestimation of the number of 15 -17 year old females in the territory.  Numerator for this reporting year is from data provided by the only 2 hospitals within the territory - Schneider Regional Medical Hospital ( St. Thomas) and Juan Luis Medical Center ( St. Croix).
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

Population data for 15-17 year females is not reported as a separate category in the VI Community Survey. Category is for 15-19 year olds for 2009 VI Community Survey. Denominator is an overestimation of the number of 15 -17 year old females in the territory.

Numerator for this reporting year is from data provided by the only 2 hospitals within the territory - Schneider Regional Medical Hospital ( St. Thomas) and Juan Luis Medical Center ( St. Croix).

**Data Alerts:** None

**NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.**

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	20.0	20.0	20.0
Annual Indicator	9.2	2.5	2.1	0.5	
Numerator	600	178	149	40	
Denominator	6,557	7,150	7,150	7,627	
Data Source	Dental Program	FQHC	FQHC	FQHC	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
Data for this denominator obtained from the 2012 USVI Census. This is a gross overestimation of the population for this group since there is no separate category for 8 and 9 year olds. The age group for this category is 5 - 9 years. Numerator is obtained from both of the Federally Qualified Health Centers in the territory. The DOH Dental Clinics have closed down.
- Field Name:** 2013

**Field Note:**  
Data for this denominator obtained from the 2010 USVI Census. This is a gross overestimation of the population for this group since there is no separate category for 8 and 9 year olds. The age group for this category is 5 - 9 years.  
  
Numerator obtained from one of the Federally Qualified Health Centers in the territory. The DOH Dental Clinics have closed down.
- Field Name:** 2012

**Field Note:**  
Data for this denominator obtained from the 2010 USVI Census. This is a gross overestimation of the population for this group since there is no separate category for 8 and 9 year olds. The age group for this category is 5 - 9 years.  
  
Numerator obtained from the Federally Qualified Health Centers in the territory. The DOH Dental Clinics have closed down.
- Field Name:** 2011

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**Field Note:**

Data for this denominator obtained from the 2009 VI Community Survey by the Eastern Caribbean Center - University of the Virgin Islands.

Numerator obtained from the DOH Division of Dental Services for the St. Thomas-St. John District. St. Croix District doesn't collect or report data for this measure.

**Data Alerts:** None

**NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.**

	2011	2012	2013	2014	2015
Annual Objective	1.0	1.0	0.0	0.0	0.0
Annual Indicator	9.8	0.0	0.0	0.0	
Numerator	2	0	0	0	
Denominator	20,416	22,134	22,134	20,747	
Data Source	VICS/OHS	Office of Highway Safety and 2010 Census	Office of Highway Safety	VI Office of Highway Safety	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
Denominator: Data is from the 2012 USVI Census of individuals ages 0 -14 years of age. Numerator: Data for this reporting year is from VI Office of Highway Safety 2013 statistics. There were no fatalities reported.
- Field Name:** 2013

**Field Note:**  
Denominator: Data is from the 2010 USVI Census of individuals ages 0 -14 years of age.  
  
Numerator: Data for this reporting year is from VI Office of Highway Safety 2013 statistics. There were no fatalities in this age group secondary to MVAs.
- Field Name:** 2012

**Field Note:**  
Denominator: Data is from the 2010 USVI Census of individuals ages 0 -14 years of age.  
  
Numerator: Data for this reporting year is from VI Office of Highway Safety 2012 statistics. There were no fatalities in this age group secondary to MVAs.
- Field Name:** 2011

**Field Note:**  
Denominator: Data is from the 2009 VI Community Survey of individuals ages 0 -14 years of age.  
  
Numerator: Data for this reporting year is from VI Office of Highway Safety 2011 statistics.

**Data Alerts:**

1.	A value of zero has been entered for the numerator for year 2013 NPM# 10. Please review your data to ensure this is correct.
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2.	A value of zero has been entered for the numerator for year 2014 NPM# 10. Please review your data to ensure this is correct.
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**NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.**

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	50.0	85.0	85.0
Annual Indicator	28.2	78.7	81.9	80.8	
Numerator	501	629	596	573	
Denominator	1,779	799	728	709	
Data Source	WIC/Hospital Data	WIC data	WIC data	WIC data	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Denominator: the denominator is the number of new mothers served by WIC for the FY 2014 ( breastfeeding and non-breastfeeding Moms). Numerator: the data is from the WIC program for 2014 and reflects the number of Moms that are breastfeeding. This is also 2% increase from 2013 as last year's 2% increase. WIC program does not indicate whether these Moms are breastfeeding still at 6 months. 32 Moms (7% of all breastfeeding Moms ) were reportedly exclusively breastfeeding.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Denominator: the denominator is the number of new mothers served by WIC for the FY 2013 ( breastfeeding and non-breastfeeding Moms). Numerator: the data is from the WIC program for 2013 and reflects the number of Moms that are breastfeeding. this is a 2% increase from 2012. WIC program does not indicate whether these Moms are breastfeeding still at 6 months. 35 Moms (6% of all breastfeeding Moms ) were reportedly exclusively breastfeeding.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Numerator: Data is from the WIC Program for this reporting year.  Denominator: Data is based on the number of new mothers served by WIC ( breastfeeding and non-breastfeeding mothers).  There are 1484 live births as reported by both hospitals in the territory. (Schneider Regional Medical Center, St. Thomas and Juan Luis Medical Center, St. Croix), but not all are served by WIC.
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

Numerator: Data is from the WIC Program for this reporting year.

Denominator: Data is based on live births statistics reported by both hospitals in the territory. (Schneider Regional Medical Center, St. Thomas and Juan Luis Medical Center, St. Croix).

**Data Alerts:** None

**NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.**

	2011	2012	2013	2014	2015
Annual Objective	95.0	95.0	95.0	90.0	95.0
Annual Indicator	85.4	82.0	87.4	82.8	
Numerator	1,519	1,217	1,166	1,071	
Denominator	1,779	1,484	1,334	1,294	
Data Source	NBS Program	NBS Program	New Born Hearing Program	New Born Hearing Program	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
Data for this reporting year obtained from Universal Newborn Hearing Program based on # live birth admissions data received from both hospitals and # screened before discharge. This information presented does not include the # screened post-discharge on an outpatient basis. An estimated 44% were screened within 2 weeks post discharge ( 89 of 204). The remainder were considered lost to follow-up after numerous attempts to contact parents were unsuccessful.
- Field Name:** 2013

**Field Note:**  
Data for this reporting year obtained from Universal Newborn Hearing Program based on # live birth admissions data received from both hospitals and # screened before discharge.

This information presented does not include the # screened post-discharge on an outpatient basis. An estimated 46% were screened within 2 weeks post discharge (128 of 278). Of the remaining 150 newborns, 65% were screened before 3 months of age. The remainder were considered lost to follow-up after numerous attempts to contact parents were unsuccessful.
- Field Name:** 2012

**Field Note:**  
This data is from the Newborn Hearing Screening data for 2012.  
The denominator represents the total live births in 2012 from the 2 hospital Nurseries.  
The numerator reflects the number of infants screened prior to discharge and does not include those that were follow-up after discharge. There is a 65 -70% follow-up rate (difference between the 3 islands) secondary to improper contact information. Loss of one of the hearing screeners resulted in a slight decrease in screening.
- Field Name:** 2011

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**Field Note:**

Data for this reporting year obtained from NBS Program based on # live birth admissions data received from both hospitals and # screened before discharge.

This information presented does not include the # screened post-discharge on an outpatient basis. An estimated 51% were screened within 2 weeks post discharge (135 of 260). Of the remaining 125 newborns, 85% were screened before 3 months of age (106 of 125). The remainder were considered lost to follow-up after numerous attempts to contact parents were unsuccessful.

**Data Alerts:** None

**NPM 13 - Percent of children without health insurance.**

	2011	2012	2013	2014	2015
Annual Objective	10.0	10.0	10.0	15.0	10.0
Annual Indicator	12.9	27.5	27.4	28.7	
Numerator	3,646	7,404	7,404	7,616	
Denominator	28,352	26,958	27,026	26,545	
Data Source	KIDS Count/VICS	KIDS COUNT/CENSUS	KIDS Count Data	VI 2012 Census Data	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2015

**Field Note:**  
 The Virgin Islands has one of the lowest rates of health insurance coverage of any state or territory in the United States (69 percent insured, 31 percent uninsured), with only American Samoa and the Commonwealth of the Northern Mariana Islands having lower coverage rates. High rates of seasonal, tourism-related work contribute to low insurance rates. Of the insured population, more than one in five residents (22 percent) receive insurance exclusively from public sources, yet public insurance rates in the Virgin Islands are lower than the national average (27 percent), in part because Medicaid dollars are capped for the territories.<sup>12</sup> Per capita federal spending on Medicaid and the Children’s Health Insurance Program is also lower in the Virgin Islands compared with federal spending on these programs in the states. <sup>13</sup> Medicaid funds allotted for USVI are capped and insufficient to provide services for all Medicaid eligible children and families.
- Field Name:** 2014

**Field Note:**  
 Data was obtained from 2012 VI Census for children < 19 yrs of age.
- Field Name:** 2013

**Field Note:**  
 Denominator obtained from 2010 VI Census for children < 18 yrs of age.  
 Numerator reflects number of children accessing services at MCH clinics in both districts with no source of insurance.  
 The Medical Assistance Program has no system in place to collect or report this data to CMS.
- Field Name:** 2012

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**Field Note:**

Denominator obtained from 2010 VI Census for children ages 0 -18 years of age.

Numerator reflects the number of children ages 0 - 18 years of age reported by 2010 KIDS Count Data for the VI that have no insurance .

The Medical Assistance Program currently has no system in place to collect or report this data to CMS.

5. **Field Name:** 2011

**Field Note:**

Denominator obtained from 2009 VI Community Survey for children ages 0 -18 years of age.

Numerator reflects the number of children ages 0 - 18 years of age reported by 2009 KIDS Count Data for the VI that have no insurance .

The Medical Assistance Program currently has no system in place to collect or report this data to CMS.

**Data Alerts:** None

**NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.**

	2011	2012	2013	2014	2015
Annual Objective	10.0	15.0	5.0	5.0	3.0
Annual Indicator	11.9	6.0	6.0	7.0	
Numerator	307	177	166	180	
Denominator	2,578	2,949	2,775	2,574	
Data Source	WIC Program	WIC data	WIC data	WIC data	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
All the data for this performance measure is from WIC data. The denominator reflects the total number of children ages 2-5 served by WIC. The numerator reflects the number of children with a BMI>85% receiving WIC services. Overweight is still the 4th risk factor seen in the children receiving WIC services.
- Field Name:** 2013

**Field Note:**  
All the data for this performance measure is from WIC data.  
The denominator reflects the total number of children ages 2-5 served by WIC.  
The numerator reflects the number of children with a BMI>85% receiving WIC services.  
Overweight is the 4th risk factor seen in the children receiving WIC services. The overall obesity rates for the VI decrease from 13.6 in 2008 to 11 in 2011 per CDC vital statistics. MMWR 8/9/13 report.
- Field Name:** 2012

**Field Note:**  
All data for this measure obtained from the WIC Program for reporting year.  
Denominator reflects the total number of children ages 2-5 yrs served by WIC.  
Numerator reflects the number children with BMI >85% receiving WIC services.
- Field Name:** 2011

**Field Note:**  
All data for this measure was obtained from the WIC Program for this reporting year.

**Data Alerts:** None

**NPM 15 - Percentage of women who smoke in the last three months of pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	1.0	1.0	1.0	1.0	1.0
Annual Indicator	1.6	0.0	0.1	0.1	
Numerator	27	0	1	1	
Denominator	1,687	1,465	1,328	1,285	
Data Source	KIDS Count/ Kaiser State Health Facts	Hospital data	Hospital data	Hospital data	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Denominator: The data is based on the reported total number of pregnant females in 2014 as reported by the two hospitals ( Roy L. Schneider Hospital and Juan Luis Hospital) . Numerator: The number of pregnant females who smoked as reported by the hospital data from nursing assessment/intake into nursery for 2014. Data for numerator reflects the # of yes responses to question "Do you smoke cigarettes or use other tobacco products?"
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Denominator: The data is based on the reported total number of pregnant females in 2013 as reported by the two hospitals ( Roy L. Schneider Hospital and Juan Luis Hospital) .  Numerator: The number of pregnant females who smoked as reported by the hospital data from nursing assessment/intake into nursery for 2013. Data for numerator reflects the # of yes responses to question "Do you smoke cigarettes or use other tobacco products?"
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Denominator: The data is based on the reported total number of pregnant females in 2012 as reported by the two hospitals ( Roy L. Schneider Hospital and Juan Luis Hospital) .  Numerator: The number of pregnant females who smoked as reported by the hospital data from nursing assessment/intake into nursery for 2012. Data for numerator reflects the # of yes responses to question "Do you smoke cigarettes or use other tobacco products?"
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

Denominator: The data is based on the reported total number of pregnant females in 2009 from the Kaiser State Health Facts.

Numerator: The number of pregnant females who smoked as reported by KIDS Count Data from 2009.

The VI does not have a Pregnancy Risk Assessment (PRAMS) database.

**Data Alerts:** None

**NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.**

	2011	2012	2013	2014	2015
Annual Objective	1.0	1.0	1.0	5.0	4.0
Annual Indicator	88.2	132.2	145.4	17.2	
Numerator	7	10	11	1	
Denominator	7,936	7,563	7,563	5,798	
Data Source	KIDS Count/VICS	KIDS COUNT/CENSUS	KIDS Count data	VI Bureau of Health Information and Statistics	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	The denominator reflects the total number of youths ages 15-19 years according to the VI 2012 Census. The numerator reflects the TOTAL number of suicides reported in 2014 by Vital Statistics.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	The denominator reflects the total number of youths ages 15-19 years according to the VI 2010 Census.  The numerator reflects the TOTAL number of teen deaths that include suicide as reported by the KIDS Count data.  The actual number of suicide deaths is currently unavailable at this time from Vital Statistics,
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Numerator: the number reported reflects the total number of teen deaths that includes suicide as reported by KIDS Count Data Center. The reported number of suicide attempts 16% (11.4% of females and 5.2% of males) of VI youth ages 15- 19 years in 2007 as reported by KIDS Count Data. Suicide may be reported or certified as accidental death, homicide or other cause of death. While anecdotal information / statistics is available regarding suicide deaths in this population, they are not identified or reported as such. This data is not currently available from Vital Statistics.  The denominator is from the VI 2010 Census for the number of youths ages 15 - 19 years of age.
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

Numerator: the number reported reflects the total number of teen deaths that include suicide as reported by KIDS Count Data Center. The reported number of suicide attempts 16% (11.4% of females and 5.2% of males) of VI youth ages 15- 19 years in 2007 as reported by KIDS Count Data.

This data is not currently available from Vital Statistics.

The denominator is from the VI Community Survey for the number of youths ages 15 - 19 years of age.

**Data Alerts:** None

**NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.**

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator	33.9	25.0	10.9	27.5	
Numerator	20	3	5	25	
Denominator	59	12	46	91	
Data Source	Hospital data	Hospital data	Hospital data	VI Bureau of Health Informaiton and Vital Statistics	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

There are only Level II Neonatal ICUs in the territory. There are no facilities for high-risk deliveries and neonates. A Neonatologist is available on each island. Level III neonates are transferred off-island. A Territorial Perinatologist provides services in both districts. In extreme instances, mothers are transferred off-island for delivery. Denominator obtained from hospitals in the territory (RLS and JFL) - the total number of low birth weight < 2,500 grams infants during calendar year 2014. The numerator reflects the number of infants < 1,500 gms born at both hospitals.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates. A Neonatologist is available in the St. Thomas-St. John District. Level III neonates are transferred off-island.

A Territorial Perinatologist provides services in both districts. In extreme instances, mothers are transferred off-island for delivery.

Denominator obtained from hospitals in the territory (RLS and JFL) - the total number of low birth infants during calendar year 2013.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates. A Neonatologist is available in the St. Thomas-St. John District. Level III neonates are transferred off-island.

A Territorial Perinatologist provides services in both districts. In extreme instances, mothers are transferred off-island for delivery.

Denominator obtained from total number of live births that are less than 1500 grams as reported by the hospitals.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates. A Neonatologist is available in the St. Thomas-St. John District. Level III neonates are transferred off-island.

A Territorial Perinatologist provides services in both districts. In extreme instances, mothers are transferred off-island for delivery.

Denominator obtained from total number of live births reported by the hospitals.

Numerator reflects # of VLBW < 1500 grams who delivered during the reporting period as per the hospital statistics.

**Data Alerts:** None

**NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

	2011	2012	2013	2014	2015
Annual Objective	70.0	70.0	70.0	75.0	80.0
Annual Indicator	38.8	61.9	69.3	61.4	
Numerator	691	918	924	794	
Denominator	1,779	1,484	1,334	1,294	
Data Source	Prenatal clinics/FQHC/Hospital data	Prenatal clinics	Hospital data	Hospital data	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Denominator reflects # live birth admissions for reporting year. Data obtained from nurseries in the hospitals in the territory. Numerator reflects # women accessing prenatal care in first trimester as reported by the hospitals in territory
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Denominator reflects # live birth admissions for reporting year. Data obtained from nurseries in the hospitals in the territory.  Numerator reflects # women accessing prenatal care in first trimester as reported by the hospitals in territory.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Denominator reflects # live birth admissions for reporting year. Data obtained from newborn screening program/ hospitals' database.  Numerator reflects # women accessing prenatal care in first trimester. Prenatal clinics in MCH and the FQHCs (2) in both districts only.  Data not available for reporting years 2011 and 2012 from DOH Office for Health Statistics.
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

Denominator reflects # live birth admissions for reporting year. Data obtained from newborn screening program/hospitals' database.

Numerator reflects # women accessing prenatal care in first trimester.

Prenatal clinics in the Community Health Center and the FQHCs (2) in both districts only.

Data not available for reporting years 2010 and 2011 from DOH Office for Health Statistics.

**Data Alerts:** None

**Form 10d**  
**State Performance Measures (SPMs) (Reporting Year 2014 & 2015)**

**State: Virgin Islands**

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

	2011	2012	2013	2014	2015
Annual Objective	700.0	700.0	700.0	750.0	750.0
Annual Indicator	388.4	626.6	694.9	613.6	
Numerator	691	918	927	794	
Denominator	1,779	1,465	1,334	1,294	
Data Source	FQHC/DOH & MCH Prenatal Clinic	FQHC/DOH/Hospitals	Hospital data	Hospital data	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Numerator reflects # of women who reported to the hospital that they received prenatal care starting in the first trimester. The denominator reflects the number of deliveries. The FQHCs and MCH Prenatal clinic numbers substantiate these numbers.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Denominator reflects the # of infants delivered.
		Numerator reflects # of women who reported to the hospital that they received prenatal care starting in the first trimester. the FQHC centers also support these high numbers.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	This is preliminary data. Denominator reflects the #of pregnant females in the territory that delivered in the reporting year.
		Numerator reflects # of women who received prenatal care starting in the first trimester at these clinics.
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

This is preliminary data.

Denominator reflects the # of prenatal patients receiving services at the FQHC & DOH & MCH Prenatal Clinics (4) during calendar year 2011.

Numerator reflects # of women who received prenatal care starting in the first trimester at these clinics.

**Data Alerts:** None

**SPM 2 - Increase the percent of CSHCN families' participation in transition planning to at least 50%.**

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	50.0	35.0	45.0
Annual Indicator	2.6	8.2	29.1	32.5	
Numerator	20	50	100	65	
Denominator	784	610	344	200	
Data Source	MCH Program	MCH & CSHCN Program	MCH & CSHCN Program	MCH & CSHCN Program	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Denominator reflects estimate of children/adolescents with special needs receiving care at both MCH Program clinic sites ages 11-18 years of age . Numerator reflects estimate of # who participated in any transition planning activities ages 11-18 years of age

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Denominator reflects estimate of children/adolescents with special needs receiving care at both MCH Program clinic sites ages 11-18 years of age .

Numerator reflects estimate of # who participated in any transition planning activities ages 11-18 years of age

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Denominator reflects estimate of children/adolescents with special needs receiving care at both MCH Program clinic sites ages 11-18 years of age .

Numerator reflects estimate of # who participated in any transition planning activities ages 11-18 years of age

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Denominator reflects estimate of children/adolescents with special needs receiving care at both MCH Program clinic sites ages 11-18 years of age .

Numerator reflects estimate of # who participated in any transition planning activities ages 11-18 years of age.

Transitioning activities begin at 11 years of age in MCH clinics.

**Data Alerts:** None

**SPM 3 - The percent of CSHCN clients who access family support services.**

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	50.0	50.0	55.0
Annual Indicator	19.9	21.0	56.6	32.6	
Numerator	219	292	400	300	
Denominator	1,098	1,389	707	921	
Data Source	MCH Program	MCH & CSHCN Program	MCH & CSHCN Program	MCH & CSHCN Program	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Denominator is based on estimate of # children with special needs receiving care at MCH program clinics during the reporting year. Numerator is based on responses from parents in the MCH survey.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Denominator is based on estimate of # children with special needs receiving care at MCH program clinics during the reporting year.  Numerator is based on responses from parents in the CSHCN survey.  There is a greater demand for services including family support than the program has the capacity to provide but will continue to partner with community-based organizations to provide needed support to families.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Denominator is based on estimate of # children with special needs receiving care at MCH program clinics during the reporting year.  Numerator is based on responses from parents in the CSHCN survey.  There is a greater demand for services including family support than the program has the capacity to provide but will continue to partner with community-based organizations to provide needed support to families.
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

Denominator is based on estimate of # children with special needs receiving care at MCH program clinics during the reporting year.

Numerator is based on responses from parents in the CSHCN survey.

There is a greater demand for services including family support than the program has the capacity to provide.

**Data Alerts:** None

**SPM 4 - The rate per 1000 of emergency department visits and hospital admissions due to asthma in children under 14 years of age.**

	2011	2012	2013	2014	2015
Annual Objective	5.0	5.0	5.0	4.0	2.0
Annual Indicator	15.9	5.4	4.5	15.3	
Numerator	324	120	100	318	
Denominator	20,416	22,134	22,049	20,747	
Data Source	RLS & JFL Hospital/ VICS	RLS & JL hospitals	MCH and FQHC	Hospital data	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Numerator is based on asthma patients seen in the MCH and FQHC clinics that had hospital admissions within FY 2013.

Denominator is the population less than 14 yrs of age according to the VI 2010 Census.

Data from the hospitals was not available at the time of this report.

2.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Numerator: Data from both island hospitals reflects in-patient admissions and ER visits. Average length of stay was 1.5 days

Denominator : data reflects the number of children ages 0-14 yrs in the territory based on the 2010 VI Census.

3.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Numerator :Data from hospitals in the territory reflect in-patient admissions only. Average length of stay was 1.5 days. 294 admissions were on St. Croix, which is more industrial than St. Thomas/St.John.

Denominator: the number of children ages 0-14 years in the territory based on 2009 VI Community Survey.

**Data Alerts:** None

**SPM 5 - Decrease the rate of hospitalizations related to morbidity associated with Type 1 diabetes for children up to age 19 years.**

	2011	2012	2013	2014	2015
Annual Objective	10.0	10.0	5.0	15.0	15.0
Annual Indicator	0.0	22.9	25.0	31.8	
Numerator	8	8	5	7	
Denominator	28,352	35	20	22	
Data Source	MCH Program	MCH Program	MCH Program	MCH data and hospital data	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

Denominator reflects the number of children with Diabetes that are enrolled in the MCH clinics. Numerator reflects the number of the children with Diabetes who have been hospitalized in FY 2014 per hospital data.

2.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Denominator reflects the number of children with Diabetes that are enrolled in the MCH clinics. Numerator reflects the number of the MCH children with Diabetes who have been hospitalized in FY 2013. Hospital data was not available at the time of this report.

3.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Denominator reflects # of children enrolled in the MCH Program who have a diagnosis of Type I diabetes.

Numerator reflects # of hospitalizations reported by family.

Hospital discharge data was not available from hospitals at time of report.

4.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Numerator: Numbers are based on patient discharge summaries provided to the MCH clinics for each of the MCH clients with Diabetes Type I disease.

Denominator: Numbers are based on population for ages 0- 19 years.

The specific data was unavailable from the hospital at the time of reporting.

**Data Alerts:** None

**SPM 6 - Increase access to comprehensive primary and preventive health care for adolescents and pre-adolescents ages 10-19 years.**

	2011	2012	2013	2014	2015
Annual Objective	10.0	10.0	15.0	15.0	20.0
Annual Indicator	9.0	7.4	7.4	8.1	
Numerator	1,323	1,116	1,119	2,152	
Denominator	14,724	15,047	15,047	26,545	
Data Source	MCH clinics/FQHC/MICS	MCH Clinics/FQHC	MCH Clinics/ FQHC	MCH Clinics/FQHC	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Data was obtained from the FQHCs and MCH clinics
2.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Denominator obtained from 2010 Census reflects # of 10-19 year olds in territory.  Numerator reflects # receiving services at MCH Program at any time during the reporting period.
3.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Denominator obtained from 2009 VI Community Survey reflects # of 10-19 year olds in territory.  Numerator reflects # receiving services at MCH Program and FQHCs at any time during the reporting period.

**Data Alerts:** None

**SPM 7 - Percent of women who abstain from alcohol use during pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	50.0	75.0	100.0
Annual Indicator	18.8	39.9	100.0	99.9	
Numerator	334	584	1,328	1,284	
Denominator	1,779	1,465	1,328	1,285	
Data Source	MCH Clinics/Hospitals	MCH & FQHC Clinics	Hospital data	Hospital data	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**Field Note:**

The data is based on clients answering the question as to whether or not they drank any alcohol during their pregnancy. The numerator is the number that said no and the denominator reflects the number of pregnant females that delivered in 2014

2.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Denominator reflects # of pregnant females that had live births this reporting year- data obtained from the hospital admission statistics.

Numerator reflects # of women who reported abstaining from alcohol 3 months before and during pregnancy as reported on Newborn hospital admissions/discharge summaries.

Data for this measure not available from DOH Office of Health Statistics at time of report.

3.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

Denominator reflects # of live births this reporting year- data obtained from the hospital admission statistics.

Numerator reflects # of women who reported abstaining from alcohol 3 months before and during pregnancy as reported on Newborn hospital admissions/discharge summaries.

Data for this measure not available from DOH Office of Health Statistics at time of report.

**Data Alerts:** None

**Form 11**  
**Other State Data**  
**State: Virgin Islands**

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

## State Action Plan Table

State: Virgin Islands

Please click the link below to download a PDF of the State Action Plan Table.

[State Action Plan Table](#)