

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

Virgin Islands

**FY 2020 Application/
FY 2018 Annual Report**

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Table of Contents

I. General Requirements	4
I.A. Letter of Transmittal	4
I.B. Face Sheet	5
I.C. Assurances and Certifications	5
I.D. Table of Contents	5
II. Logic Model	5
III. Components of the Application/Annual Report	6
III.A. Executive Summary	6
III.A.1. Program Overview	6
III.A.2. How Federal Title V Funds Support State MCH Efforts	11
III.A.3. MCH Success Story	11
III.B. Overview of the State	12
III.C. Needs Assessment	21
FY 2020 Application/FY 2018 Annual Report Update	21
FY 2019 Application/FY 2017 Annual Report Update	23
FY 2018 Application/FY 2016 Annual Report Update	27
FY 2017 Application/FY 2015 Annual Report Update	31
Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)	35
III.D. Financial Narrative	50
III.D.1. Expenditures	52
III.D.2. Budget	54
III.E. Five-Year State Action Plan	57
III.E.1. Five-Year State Action Plan Table	57
III.E.2. State Action Plan Narrative Overview	58
<i>III.E.2.a. State Title V Program Purpose and Design</i>	58
<i>III.E.2.b. Supportive Administrative Systems and Processes</i>	61
III.E.2.b.i. MCH Workforce Development	61
III.E.2.b.ii. Family Partnership	62
III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts	63
III.E.2.b.iv. Health Care Delivery System	64
<i>III.E.2.c State Action Plan Narrative by Domain</i>	69
Women/Maternal Health	69
Perinatal/Infant Health	80

Child Health	96
Adolescent Health	109
Children with Special Health Care Needs	125
Cross-Cutting/Systems Building	134
III.F. Public Input	138
III.G. Technical Assistance	142
IV. Title V-Medicaid IAA/MOU	143
V. Supporting Documents	144
VI. Organizational Chart	145
VII. Appendix	146
Form 2 MCH Budget/Expenditure Details	147
Form 3a Budget and Expenditure Details by Types of Individuals Served	152
Form 3b Budget and Expenditure Details by Types of Services	154
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated	157
Form 5 Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V	160
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX	164
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data	166
Form 8 State MCH and CSHCN Directors Contact Information	168
Form 9 List of MCH Priority Needs	171
Form 9 State Priorities-Needs Assessment Year - Application Year 2016	172
Form 10 National Outcome Measures (NOMs)	174
Form 10 National Performance Measures (NPMs)	212
Form 10 State Performance Measures (SPMs)	225
Form 10 Evidence-Based or –Informed Strategy Measures (ESMs)	229
Form 10 State Performance Measure (SPM) Detail Sheets	242
Form 10 State Outcome Measure (SOM) Detail Sheets	246
Form 10 Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets	247
Form 11 Other State Data	260

I. General Requirements

I.A. Letter of Transmittal



**GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES**

VIRGIN ISLANDS DEPARTMENT OF HEALTH

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July 9, 2019

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Maternal and Child Health Bureau
Health Resources and Services Administration
Room 5C-26, Parklawn Building
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Subject: Virgin Islands Title V FY2018 Annual Report / 2020 Application Program Plan

Dear Ms. Lawler:

Please find attached, the formal application for the Maternal Child Health Services Block Grant application for Fiscal Year 2020, as authorized by Title V of the Social Security Act (as amended by public Law 97-35, 100-71 and 100-93). It complies with the notification requirements of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and OMB control number 0915-0172.

The Maternal and Child Health services Title V Block Grant Program Guidance and forms for the FY 2020 Application and the FY 2018 Annual Report were fully utilized. All components of the application, annual report and required data forms are electronically submitted with this letter. Assurances and certifications are on file in the program's office as required in the Block Grant guidance.

We look forward to your favorable approval of this document.

Sincerely,

A handwritten signature in blue ink that reads "Justa Encarnacion".

Justa Encarnacion, RN, MBA/HCM
Commissioner of Health

JE/dp

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Program Overview

In September of 2017, the US Virgin Islands were hit by two category five hurricanes within a two-week window- a historic and catastrophic event. The widespread loss of electricity, communication and the destruction of homes, businesses, and service providers sites lead to a change in normal operating procedures for the Department of Health and its programs. The Department took services into the neighborhoods, preschools, churches, parking lots, and playgrounds to reach the more vulnerable population. The health vans were deployed and employees went out in available vehicles to reach families current and new. MCH served as a point of distribution in both districts and remained an active part of the emergency response well into 2018.

In January 2018, MCH served over one thousand families in the territory with a recovery themed baby shower with the help of new and current partners of the Department of Health; NFP, VI Partners for Families, WIC, Princess Cruises, Fathom (provider of baby supplies), the Department of Tourism, along with FEMA, the MIECHV and other programs in the Department of Health. Throughout 2018, the MCH program demonstrated tremendous effort, commitment, and hard work as responders and health care providers. Each day MCH staff aim to do their best to provide access to care for our families in spite of numerous challenges and obstacles. Almost two years have passed since we were met with unseen challenges as our islands were ravaged by hurricanes Irma and Maria. We continue to see an increase in the need for services across the Territory.

Recaps from 2018:

MCH remained displace on St. Croix throughout 2018. Prenatal, Audiology, Case Management, Home Visiting, and care coordination services continued with administrative, programmatic, and clinical services operating out of a tent and mobile health van. Prenatal services were relocated to MCH on St. Thomas after the storms and officially transitioned in 2018. Our home visiting programs- Nurse Family Partnership and Healthy Families VI are seeing their highest client loads to date. In light of the dire need, MCH resumed providing monthly pediatric services on St. John. In July, MCH faced a tremendous task of absorbing all immunization services for the pediatric population in a short period of time. In August, the program was tasked with assuming responsibility for the CMS Zika grant and received notice that our Project LAUNCH grant had been approved. In October, MCH resumed pediatric neurology services on St. Croix. Despite the loss of some key staff, and the added requirements of complex and cumbersome procedural changes to the procurement process, the program ended the year with the high levels of spending for each our programs. The MCH Leadership and Fiscal teams resumed meetings to facilitate communication and exchange across programs and districts while supporting accountability, productivity, efficiency, and focus.

Recognition

In 2018, the Program was recognized through the American Public Health Association's Effective Practice Award for the leadership of Dr. Derval Petersen in the response efforts post Hurricanes Irma and Maria. Many of our staff were directly impacted by the storms, expectations were high and days were short. Staff showed the strength of kindness and the sinew of humanity. In 2019, the program received further accolades by the Association of Maternal Child Health Programs with an Emerging Leader Award under the guidance of Dr. Petersen.

Accomplishments 2018/2019:

- The USVI MCH Program has benefited from an improved working relationship between Title V and Title 19. These efforts have resulted in the enhanced ability to request and obtain data for the Medicaid eligible MCH

population in the Territory, as well as thru capacity building efforts thru the provision of staff training on presumptive eligibility.

- Though displaced, MCH continued to provide services and operate out of the tent and mobile health van on St. Croix up to April 2019.
- Prenatal services were relocated to MCH on St. Thomas after the storms and officially transitioned in 2018.
- MCH's Maternal Infant and Early Childhood Home Visiting Program was taken off of restrictions in 2018 due to a coordinated, intentional, and consistent effort to meet funder requirements and ensure program performance.
- Both home visiting programs- Nurse Family Partnership and Healthy Families VI are seeing their highest client loads to date.
- 9 Graduates were celebrated in March this year from the NFP Program.
- In light of the dire need, MCH resumed providing monthly pediatric services on St. John
- Last August, due to the exigent need post hurricanes, MCH received approval and funding to move forward with the Territory's first Project LAUNCH program to support the social emotional development of children 0-8.
- MCH ended the year with high levels of spending for each our programs.

Goals for 2019/2020:

Over the last 2 years, MCH has significantly grown with the addition of 3 new federal grants, along with the transition of prenatal services on St. Thomas and pediatric immunization services in both districts. Upcoming projects for the Division include:

- Adolescent Health Clinic
- Survey of Children's Health
- Title V and MIECHV Needs Assessment
- Tele-health implementation
- Project LAUNCH implementation

Challenges

Hiring and staff shortages remain a challenge for the program. For FY18, the Division had approximately twenty vacancies across the MCH grant portfolio. The program has worked with the Department of Health's financial services division to reprogram local funding in order to hire much needed administrative support. The Division continues to work closely with the HR team to identify and address any issues in the hiring process to ensure that recruitment efforts are actively moving forward.

In July 2018, the Office of Management and Budget imposed new regulations that made it even more challenging to spend funds with the newly implemented Executive Order placing OMB in the middle of the Requisition and Payment process. Despite diligent efforts on the part of the program to encumber and expend monies, the process impeded the ability to spend funds timely. Justification letters were returned, SAMS searches had to be conducted for each vendor, and requisitions sat unapproved for extensive periods of time. MCH ended the FY 18 fiscal year with unobligated funds due to these severe infrastructure and systems challenges.

MCH & CSHCN Overview

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 '18, 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
- Audiology Services
- Head Start Screening and Early Head Start Screenings (Develop/Hearing/Vision)
- Home Visiting Services (Nurse Family Partnership and Healthy Families America)

Throughout FY'18, 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 serves as both local and state agency. This single State agency is authorized to administer Title V funds and is responsible for both Maternal and Child Health and Special Needs Children Services. 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.

Child health services promote optimal health, safety, and well-being of all infants, children and adolescents birth to 21 years through preventive practices and strategies along a developmental continuum of growth and development. Services provided include immunization; health education and counseling regarding healthy lifestyle choices; assessment for age appropriate growth and development; monitoring for other underlying health problems; and physical examinations with promotion of healthy child care practices. Referrals are done for oral health care, hearing screening, early intervention services, specialty clinics, and home visits.

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.

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.

Maternal Health

The program continues to support prenatal, post-partum, and inter-conceptual care and works closely with Family Planning, WIC, Communicable Diseases, and Behavioral Health to ensure wraparound services for our clients. Post-partum visits were expanded to include 2, 4, and 6 week check-ups to monitor self and infant care, post-partum depression, and provide general support new moms after delivery.

Program planning for the implementation of a Centering program for our pregnant women was suspended post

storms due to damage of the facility. Once site assessments at the new location are complete, the Division will resume working towards implementation of this evidence-based model of care.

Child Health

MCH & CSHCN continues to partner with community based organizations such as Early Head Start-Lutheran Social Services and Preschool Education Program-Department of Education, and both Federally Qualified Health Centers to develop and distribute information cards on health, nutrition, developmental screening, 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

The program remains the medical home for many 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

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.

Maternal, Infant and Early Childhood Home Visitation Program (MIECHV):

The MCH program was appointed the lead agency for the MIECHV grant in order to improve health and development outcomes for at-risk children through evidence-based home visiting programs. MCH has implemented two different evidence-based home visitation models in the VI: Nurse Family Partnership (NFP) in St. Thomas and Healthy Families America (HFA) in St. Croix. The HFA Program resumed services in FY16.

Zika MCH Services

MCH & CSHCN serves as the primary point of care coordination and follow-up for babies born to Zika positive moms. These activities are funded under the HRSA funded Zika MCH Services grant. During the height of transmission, MCH also served as the center for pregnant moms to receive Zika Prevention Kits and has participated in numerous local outreach activities to promote community awareness on the effects of the Zika virus.

Partnerships

Partners and collaborators include a wide array of government, private and non-profit entities. 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, University of the Virgin Islands, Department of Human Services, Early Head Start,

the Community Foundation, Women's Coalition, and the hospitals. National partners included AMCHP, NCHAM, Early Childhood Hearing Outreach, Florida and Southeast Deaf Blind Association, Northeast and Caribbean Injury Prevention Network, ASTHO and NICHQ. Parent and consumer participation and involvement via the MCH Advisory Council is being strengthened, and advocacy support through Family Voices and Hands and Voices is being explored.

III.A.2. How Federal Title V Funds Support State MCH Efforts

Title V Support in MCH efforts

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 Program looks at various areas and populations to identify underserved MCH individuals in order to commit resources to provide appropriate services for this population.

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. Title V remains the payor of last resort.

III.A.3. MCH Success Story

MCH Success Story

As the Family Representative, I am very proud to say MCH has helped many families in different ways. I am the first employed family representative by the VI MCH Program. Our program helps families receive financial assistance with medical services like with my granddaughter, Keiera's MRIs, CT Scan, and Doctor Visits, as well as emotional support group at MCH. I advocate for parents and encourage their engagement in our program.

Keiera with her disability has experienced a big turnaround and is an Honor Roll Student in the 7th grade with an 89 grade point average and plays sports (basketball and volleyball). With Family support, IEP Team (Department of Education), V.I. Deaf and Blind, and the Department of Health Family Division, Keiera will still be somewhere more beneficial with her disability.

Keiera is presently being treated by the Pediatric Otolaryngology at the Joe DiMaggio Children Hospital. She was diagnosed as a baby who did not develop her stapes bone in the ear and has a cholestoma in between her earwall, all of her 5 nerves are embedded in the cholestoma. Keiera is presently waiting for her device called the Adhear from Med-El to help amplify sound.

With my experiences with MCH, I have been blessed with the opportunity to share her story and to also provide parents in general with newborns, the assistance of having hearing screenings done to better understand how important it is to screen early for the betterment of the child's future.

III.B. Overview of the State

State Overview

In September 2018, marking the one year anniversary post Hurricanes Irma and Maria, the Government released an extensive hurricane recovery report outlining the cumulative effects of the storms in damages to infrastructure and systems. The report spoke to underlying factors that compounded damages and provided a guide toward long-term recovery efforts intended to strengthen infrastructure and systems throughout the Territory. The following updates are cited from the USVI Hurricane Recovery and Resilience Task Force report:

The storms severely damaged the islands' critical infrastructure, knocking out electricity and telecommunications for months, blocking roads, shutting down ports and airports, damaging water and wastewater facilities, generating hundreds of thousands of tons of debris, and damaging more than half of the Territory's housing stock. Total damage is estimated at \$10.7 billion: \$6.9 billion to infrastructure, \$2.3 billion to housing, and \$1.5 billion to the economy. Specific damage included:

- Energy: More than 90 percent of aboveground power lines were damaged and more than half of all poles were completely knocked down. Customers on all three large islands experienced total service outages, most for at least several weeks. Over 90 percent of customers who could accept power were restored by January 1, 2018.
- Transportation: Airports on St. Croix and St. Thomas closed for two weeks and reopened with only limited capacity. Seaports closed for three weeks due to the sinking of more than 400 vessels; roads blocked with debris and the loss of power to traffic lights—or the lights themselves—resulted in a more than a sevenfold increase in crashes at intersections.
- Housing: 52 percent of all housing stock was damaged (12 percent damaged severely); renters and low- and moderate-income (LMI) households were disproportionately affected. Senior centers were closed and homes for the elderly were damaged.
- Health: Both of the Territory's main hospitals were severely damaged to the point of becoming nonoperational for most services; total daily inpatient capacity across the Territory was down 50 percent and hundreds of patients were evacuated to the mainland and have been unable to return because services like dialysis and cancer treatments are no longer available.
- Education: All public schools closed for over a month, with 17 of 31 schools more than 50 percent damaged. Once open, most public schools operated on split sessions until the end of the academic year, and private schools saw steep enrollment drops.
- Economic impacts: Hotel reservations saw a 78 percent drop in December 2017 compared to a year before; by June 2018, major airlines were still reporting a 43 percent drop in flight seats available compared to a year before. There were 4,300 additional jobless claims after the storms, with roughly 8 percent of all jobs lost, comparatively marking the third worst job loss from a US hurricane in the last 30 years.

Source: USVI Hurricane Recovery and Resilience Task Force Report, 2018

US Virgin Islands 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. The 2010 US Census estimated that Males represented 48% (50,867) of the population with females at 52% (55,538). In 2014, the USVI Community Survey indicated a total of 102,007 persons representing a 6% decrease from 2010. The breakdown by gender and distribution remain roughly the same with 52% female, 48% male; 47% living on St. Croix and 53% living in the St. Thomas/St. John district.

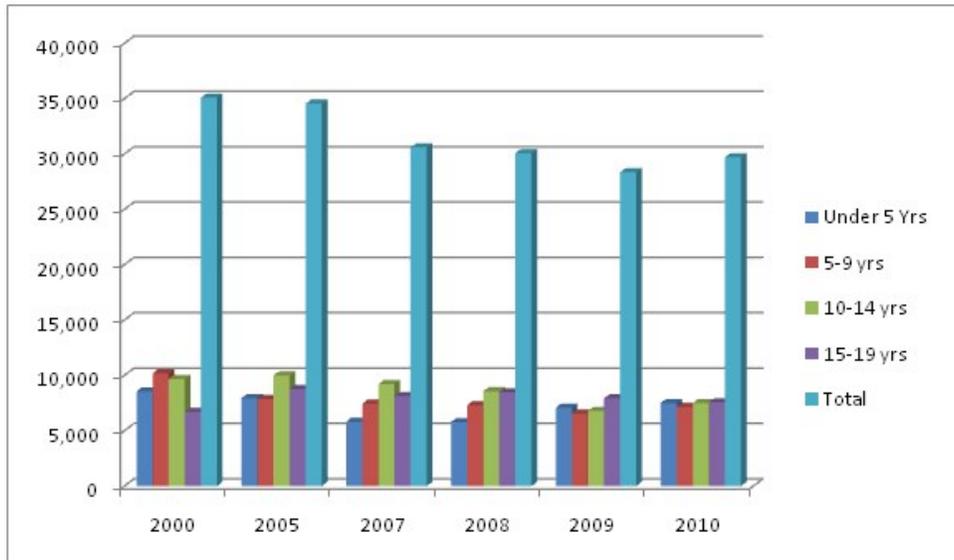
Population less than 19 years

In 2013, children represented 21% of the population, down from 24% in 2010 and 32% in 2000 and similar to the nation which was 23% for 2013. Over the past thirteen 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.



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%. Most recent estimates from the 2014 Virgin Islands Community Survey (VICS) characterize the population as 77% *Black* (African American or African Caribbean), 10.5% *White*, and 12.4% *Other Races* with 17% of the population reporting Hispanic origins.

Year	Census 2000		2007		2008		2009		2010	
Population	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Black/African American	82,750	77.3%	88,336	76.9%	89,341	77.1%	82,406	76.8%	80,908	76.04%
White	14,218	10.6%	10,183	8.87%	10,892	9.4%	9,616	8.9%	16,646	15.64%
Other Races	11,644	12.1%	16,225	14.2%	15,619	13.5%	15,321	14.3%	8,851	8.32%

Population by Hispanic or Latino Origin

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.

Languages Spoken in the Home

According to 2010 Census results, of the various 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, which is inclusive of those that are undocumented. Many of the persons who migrated to the territory seeking employment establish citizenship here.

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.

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. The most recent 2016 VI Kids Count reported increased poverty levels for USVI families with children (32%, up from 27% in 2012) as well as increases in the number of children in the USVI living in poverty (37%, up from 35% in 2013). The highest number of children in families living below the poverty line are recorded on St. Croix (41%). The magnitude of the challenge poverty imposes on the Virgin Islands community is visible in data reporting 47% (up from 44% in 2013) of single female head of household families living in poverty (below the federal poverty level). These percentages are even higher for female-headed families with children under six years of age, with 58% of these families categorized as poor, compared to 44% of female-headed households with children ages 6 – 17 (CERC, 2019).

In 2014, roughly half (49.6%) of all children under age 6 (2,700 children) lived in families in poverty, compared to 32% of children age 6 to 17 (4,084 children). Children in St. Croix had the highest poverty rate of the islands at 40.6% (nearly the same as the rate in 2013: 40.5%). In St. Thomas, 34% of children lived in families in poverty (up from 29% in 2013). In St. John, 14% of children lived in families in poverty (a decrease of 10% percentage points from 2013) (2016 Kids Count).

The 2014 poverty threshold, adjusted for family size, was \$24,008 in annual income for a family of four with two related children under age 18. Because the cost of living (for food, housing, energy etc.) in the USVI is documented as among the nation's highest, actual VI poverty levels are likely higher than indicated. Despite the general rise in median family incomes, more than a quarter of families with children reported incomes below the federal poverty level in 2014. Families headed by single mothers are especially vulnerable to poverty. Children's families headed by unmarried females made up the majority of all poor families, representing just over $\frac{3}{4}$ (76%) of all families (with children) in poverty, similar to that in 2013 (74.5%) and 2010 (74.7%). Almost five out of every 10 single-female families with children lived below the federal poverty level (47.1%, up from 43.7% in 2013, and 39% in 2012, but similar to the rate of 47.8% in 2010) (2016 Kids Count).

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.

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.^{[1][2]} 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.^{[2][3]}

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 was 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 undoubtedly had a large impact on all businesses including landlords, retailers, restaurants, bars, private schools, and so forth.^{[3][4]}

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.³⁷ 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.

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.

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.

D. 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.

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).

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. 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).

Medicaid Cap

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.

MAP in the VI provides medical assistance based on income and asset test of individuals and families that are medically and categorically eligible. The poverty threshold for annual allowable income to qualify for Medicaid in the VI is \$17,888 for a family of four compared to the national average of \$33,465 (Census Bureau 2014) for a family of four. 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. Government programs, clinics and hospitals (3) provide health care services at little or no cost. Everyone, including low income, uninsured or underinsured individuals and families have access to essential services. Prenatal patients with Medicaid coverage do not have the ability under program requirements to access care at private providers which limits their choices of providers.

One limitation of the expanded Medicaid program is that income eligibility will remain fixed at \$5,500 for new enrollees—mostly adults without children. This provision will limit the availability of health insurance coverage among lower-income residents. Medicaid coverage is also limited by the federal match formula that requires the Virgin Islands to cover much of the costs of providing coverage. This match will improve under the ACA (changing to 55 percent federal, 45 percent local funding) but still represents a significant burden for the territory.

The USVI Department of Health's MCH Program is currently working towards updating the Title 5/Title 19 Inter-

agency agreement with the Department of Human Services.

ACA Fiscal Cliff--As a result of the hurricanes, there has been an increase in demand for Medicaid services, an increase in our Medicaid-eligible population, as well as increased demands for reimbursement from states providing services to displaced Virgin Islands residents. These factors will substantially increase Medicaid costs which will accelerate the rate at which federal Medicaid funds are accessed. Consequently, because of the hurricanes, there may be little or no ACA Medicaid allotment remaining as of September 30, 2019. Thus, elimination of the cap on Territorial Medicaid reimbursements or a renewal of the ACA allotments would extend the availability of any remaining ACA allotment beyond September 30, 2019 "fiscal cliff". If the "fiscal cliff" is not addressed by September 30, 2019, the Virgin Islands' Medicaid program will be at risk, and up to 35,000 U.S. citizens-35% of our population-could lose access to healthcare coverage under Medicaid. Given the lack of a viable healthcare insurance market in the Territory, our low-income population would have *nowhere else* to go for healthcare coverage (COH Testimony).

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 Disparities

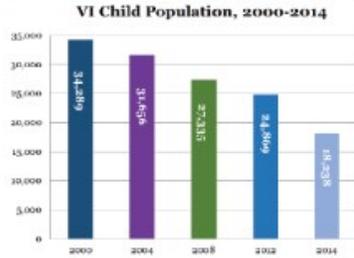
Geography (location of services for clients, transportation deficits), race and ethnicity (cultural competency, language barriers), and socioeconomic (under or un-insured, low-income, at-risk) all play significant roles in the existence of health disparities for our population. This can often be seen in the predisposition or incidence of disease, lack of access and availability to care, high emergency room use, lack of health literacy and improper use of medications. In the VI, these considerations are all crucial in addressing the exigent need and demonstrate the importance of health awareness in our community. During the past three years, in addition to the usual social determinants of health such as poverty, limited educational attainment, crime and violence victimization/ perpetration, poor environment and sub-standard housing, the VI witnessed new risk factors in the form of displaced former HOVENSA employees made especially vulnerable due to their often progressed chronic disease, age, lack of health insurance and viable employment (VIPHC Report). The VI will continue employing a strengths-based approach to address prevalent health disparities through continuing partnerships and sharing resources to support our vulnerable populations.

Poverty remains one of the greatest threats to our children's wellbeing in the USVI. In 2014, 49.6% of children under the age of 6 lived in families in poverty. By island, the poverty rates are disproportionately higher with 41% of children living with families in poverty on St. Croix, 29% on St. Thomas, and 24% on St. John (Kids Count 2016).

Kids Count

The USVI Kids Count Data Book provides a comprehensive and notable look at the wellbeing of our children through demographical and socioeconomic lens. Key findings from the 2016 USVI Kids Count Report are included below:

Child & Family Demographics



Child Population by Age Group, 2014



VI Child Population by Age Group, 1990-2014

Year	0-4	5-9	10-14	15-19	0-18 as % of total		
1990	35,427	26,167	26%	9,239	19,272	10,142	5,623
2000	34,286	25,726	25%	8,523	10,176	5,676	8,688
2010	27,025	19,425	28%	7,209	7,139	7,484	7,522
2014	18,238	14,125	17%	4,110	5,199	5,277	5,415

VI Child Population

The number of children (under 18) living in the USVI in 2014 continued its decline, decreasing by over 16,000 children (or 47%) since 2000. Similarly, the portion of children in the population also demonstrated a continued decrease -- with children representing 18% of the total population in 2014, compared to 20.5% in 2013 (which was more similar to the national rate of 23%).

Population decline in the VI has been a trend not only within the child population but within the overall population as well, as over the last 14 years the total population has decreased by an estimated 6%.

*Declining fertility and immigration rates, combined with longer life expectancy, low contributed to population aging in the Virgin Islands. The median age of the population in the Virgin Islands has increased sharply from 26.2 in 1990 to 33.4 in 2000 to 39.2 in 2010. In the USVI, as in many rural counties and certain cities in the United States, there are not enough new births or young people moving to the territory to balance the aging of the population.¹⁶

• In 2014, there were 18,238 children (birth to age 18) in the VI, representing 3,233 fewer children than in 2013, and 16,051 fewer children than in 2000.

...by island*:

Reflecting a continued trend over the past 10 years, children continue to represent a smaller portion of each island's population, with another decrease in 2014.

The proportion of children in the total population was higher in St. Croix (children made up 20.2% of all residents), than St. John (children made up 10.7% of all residents) and St. Thomas (children made up 16.2% of all residents).

- St. Croix: 9,675 children represented 53% of all VI children, 1,502 (13%) fewer children than in 2013.
- St. John: 476 children represented 2.6% of VI children, 29 (6%) fewer children than in 2013.
- St. Thomas: 8,087 children represented 44.3% of all VI children, a decrease of 1,700 (17%) from 2013.

* Population Reference Bureau, 2014 Report

TABLE 1. Trends in Indicators of VI Children's Well-being, 2012-2014

		2012	2013	2014	
Child & Family Demographics	VI Child Population	27,026	21,741	18,238	Decreased
	Children in Single-Parent Families	50%	59%	59%	Increased
	Children in Married-Parent Families	24%	36%	36%	Increased
Economic Well-Being	Median Family Income	\$43,606	\$41,839	\$44,521	Varied
	Children in Poverty	31%	35%	37%	Worsened
	Detached Youth	14%	27%	19%	Varied
Education	5 Year Olds Behind Developmental Age Expectations Language and Comprehension	53%	55%	51%	Varied
	5 Year Olds Behind Developmental Age Expectations Cognition Skills	34%	40%	39%	Worsened
	Public High School Dropouts	5.2%	7%	5.8%	Varied
Health & Safety	Low-Birthweight Babies	9.6%	8.7%	5.30%	Improved
	Teen Birth Rate	48/1,000	36.3/1,000	33.6/1,000	Improved
	Children Without Health Insurance	28%	27%	26%	Static
	Teen Death Rate	207/100,000	58/100,000	149/100,000	Varied

III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

Needs Assessment Activities and Updates

The MCH & CSHCN Program has entered into a collaboration with the University of Chicago through HRSA to develop a Children's Survey that collects data for the territories. The National Opinion Research Center (NORC) at the University of Chicago was responsible for obtaining OMB approval, while the Virgin Islands and other jurisdictions participated in several discussion and questionnaire/survey reviews to finalize the instrument in addition to an SSDI Jurisdictional meeting at AMCHP. The instrument was finalized, and OMB approval was obtained in 2019. Testing of a small sample occurred in the Spring of 2019. NORC began training in July of 2019 and implementation followed shortly thereafter. The survey process is anticipated to last two weeks and will be conducted on all three major islands (St. Thomas, St. Croix and St. John).

The Association of State and Territorial Dental Directors reached out to Title V regarding conducting a territorial dental needs assessment in the USVI. The survey is intended to identify capacity, determine needs and provide recommendation to public health stakeholder on how best to address unmet needs around oral health.

The MCH & CSHCN Program continues to use SSDI funding to support and strengthen Title V data capacity and initiatives. The VI uses in-kind efforts towards the development of the Title V Needs Assessment, SPM and ESM measures, the annual Block Grant report and application, and COIIN activities. SSDI retained a fulltime position and has worked to that to the extent possible, data collection processes are identical across the territory. General data staff remains an issue, and Title V staff continue to advocate for the need to quickly fill the three current vacancies.

Title V has engaged multiple partners in the process of conducting multiple needs assessment which are all due by July 2020. These partners include but are not limited to: University of Chicago's National Opinion Research Center, Child Trends and Island Analytics. Survey instruments have been approved and key stakeholder interviews have begun. Collection of client surveys by NORC, which will provide data like that which is being captured by the National Survey of Children's Health has begun. Island Analytics will play a significant role in the collection of data from families; within the public health clinics and the Federally Qualified Health Centers. Island Analytics will also act as a liaison with public and non-profit organizations to garner direct feedback from youth and families. These instruments will be used continuously for process and client satisfaction improvement.

The University of the Virgin Islands' Caribbean Exploratory Research Center conducted a needs assessment to document the programs and services available in the USVI post Hurricanes Irma and Maria, the needs of children and their families, gaps in services and efforts to address those gaps, and provision of information to policy makers and stakeholders. Title V provided secondary data, participated key informant interviews and post-data collection reviews. The key findings of the study indicate that stress remains a significant health issue for residents in the aftermath of the two hurricanes, with elementary school aged children at increased risk for post-traumatic stress disorder. The report also highlighted program and service gaps that were most prominent in the aftermath of the storms: behavioral services for children, the availability of school counselors, limited dental care and limited capacity with respect to patient care.

FY 2019 Application/FY 2017 Annual Report Update

//2017//

The MCH & CSHCN Program has entered into a collaboration with the University of Chicago through HRSA for the purpose of developing a Children's Survey that collects data for the territories. The National Opinion Research Center (NORC) at the University of Chicago was responsible for obtaining OMB approval, while the Virgin Islands and other jurisdictions participated in several discussion and questionnaire/survey reviews to finalize the instrument in addition to an SSDI Jurisdictional meeting at AMCHP. The final instrument will be implemented by NORC in a test modality and later be utilized to provide on-going data in the area of children's health.

//2016//

Program Activities and updates

Over the course of year, the MCH Program continued working with collaborative partners within DOH to ensure coordination of care for our families affected by the Zika virus. Monthly meetings are held with the key divisions within the Department to include Epi Division, Public Health Preparedness, MCH, Infants and Toddlers, and Environmental Health.

Dental Care remains a concern with a lack of providers to sustain and provide the level of services needed. Both FQHC's continue to provider dental services but also report a consistant wait list of approximately one year out. Frederiksted Health Care Inc, and St. Thomas East End Medical Center recently received funding through MCHB for Zika support with the option of expanding dental services. Through these funds, both sites have chosen to expand their dental capacity. MCH is also exploring the resumption of dental services under the Department of Health with the support of an approved Technical Assistance request through HRSA to explore capacity and sustainability.

While the Program has seen a reduction in the workforce on St. Croix, one of the full-time Pediatricians on St. Thomas continues to help providing services for the pediatric population on St. Croix. It is our expectation that a full-time Pediatrician will be hired in the coming fiscal year; a Pediatric Nurse Practitioner is also being sought to supplement services on St. Croix.

The MCH program procured two Kiosks that contain the same information as above (Safe Sleep environment and Healthy Nutrition Habits) that are interactive tools to be utilized in the clinics. The unveiling and placement occurred in May 2016.

SSDI

The MCH & CSHCN Program continues to use SSDI funding to support and strengthen Title V data capacity and initiatives. The VI uses in-kind efforts towards the development of the Title V Needs Assessment, SPM and ESM measures, the annual Block Grant report and application, and COIIN activities. A full-time position for SSDI has been posted and recruitment is underway.

//2015//

Throughout FY '16, 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.

The Virgin Islands MCH & CSHCN identified the following top 9 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
8	Teenage pregnancies	Adolescent Health
10	Transition	Children with Special Health Care Needs
12	Oral Health	Cross-cutting/ Life Course

A 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.

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.

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

In 2013, the low birth weight for the USVI was 8.7% down from 9.6% in 2012 and 10.6% in 2011 representing a continued decline over past years but still notably higher than the national rate of 8.0%^[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, MCH 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 December 31, 2016, 1075 women enrolled in the VI. Additionally, the USVI is now ranked #2 down from #1, among all states and territories for the number of women per 1000 estimated pregnancies and births.

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%)^[2]. Overall, 55 percent of respondents indicated that their child had a medical need.^[3] 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.

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.

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.^[4]^[4] 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 Title V program will continue to provide access to services, i.e. diagnostic, laboratory, specialty and sub-specialty care for families with no insurance coverage who are not eligible or do not meet certification standards for the Medical Assistance Program.

In light of the specific needs of our populace and the scarcity of available resources, the MCH & CSHCN Program will continue its joint efforts towards reaching and improving the health and well-being of the mothers, infants, children and youth, including children and youth with special health care needs, and their families in the VI through collaborative local, state, and federal partnerships. Targeted strategies will be employed to expand outreach and support to our culturally diverse population, enhance provider and community collaboratives; identify barriers that prevent families from accessing health care on a regular basis; encourage family-professional partnerships in all program activities, i.e. include families in all workgroups, advisory committees and provide adequate compensation for their time; and encourage and promote participation in parent mentor/support groups to families, family advocacy organizations and providers.

FY 2018 Application/FY 2016 Annual Report Update

Throughout FY '16, 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.

The Virgin Islands MCH & CSHCN identified the following top 9 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
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8	Teenage pregnancies	Adolescent Health
10	Transition	Children with Special Health Care Needs
12	Oral Health	Cross-cutting/ Life Course

A 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.

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.

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

In 2013, the low birth weight for the USVI was 8.7% down from 9.6% in 2012 and 10.6% in 2011 representing a continued decline over past years but still notably higher than the national rate of 8.0%^[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, MCH 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 December 31, 2016, 1075 women enrolled in the VI. Additionally, the USVI is now ranked #2 down from #1, among all states

and territories for the number of women per 1000 estimated pregnancies and births.

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%).^[2] Overall, 55 percent of respondents indicated that their child had a medical need.^[3] 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.

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

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//2016//

Program Activities and updates

Over the course of year, the MCH Program continued working with collaborative partners within DOH to ensure coordination of care for our families affected by the Zika virus. Monthly meetings are held with the key divisions within the Department to include Epi Division, Public Health Preparedness, MCH, Infants and Toddlers, and Environmental Health.

Dental Care remains a concern with a lack of providers to sustain and provide the level of services needed. Both FQHC's continue to provider dental services but also report a consistent wait list of approximately one year out. Frederiksted Health Care Inc, and St. Thomas East End Medical Center recently received funding through MCHB for Zika support with the option of expanding dental services. Through these funds, both sites have chosen to expand their dental capacity. MCH is also exploring the resumption of dental services under the Department of Health with the support of an approved Technical Assistance request through HRSA to explore capacity and sustainability.

While the Program has seen a reduction in the workforce on St. Croix, one of the full-time Pediatricians on St. Thomas continues to help providing services for the pediatric population on St. Croix. It is our expectation that a full-time Pediatrician will be hired in the coming fiscal year; a Pediatric Nurse Practitioner is also being sought to supplement services on St. Croix.

The MCH program procured two Kiosks that contain the same information as above (Safe Sleep environment and Healthy Nutrition Habits) that are interactive tools to be utilized in the clinics. The unveiling and placement occurred in May 2016.

SSDI

The MCH & CSHCN Program continues to use SSDI funding to support and strengthen Title V data capacity and initiatives. The VI uses in-kind efforts towards the development of the Title V Needs Assessment, SPM and ESM measures, the annual Block Grant report and application, and COIIN activities. A full-time position for SSDI has been posted and recruitment is underway.

FY 2017 Application/FY 2015 Annual Report Update

Throughout FY '15, 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.

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.

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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.

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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%[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, MCH 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.

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.

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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).*

Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)

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) CHSCN, e) Adolescent Health, f) Cross-cutting or Life Course; A) Preventive 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 6th and 7th 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.

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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.^[2] 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 o 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]³

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 sub-specialty 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.

[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

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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]³

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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 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.

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.

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,464,800	\$1,464,800	\$1,473,657	\$1,473,657
State Funds	\$848,793	\$839,200	\$1,169,459	\$1,169,459
Local Funds	\$273,375	\$270,971	\$0	\$0
Other Funds	\$62,123	\$62,123	\$0	\$0
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$2,649,091	\$2,637,094	\$2,643,116	\$2,643,116
Other Federal Funds	\$1,345,374	\$1,303,124	\$1,345,374	\$235,326
Total	\$3,994,465	\$3,940,218	\$3,988,490	\$2,878,442
	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,473,690	\$1,488,491	\$1,479,815	
State Funds	\$1,300,000	\$1,300,000	\$0	
Local Funds	\$0	\$0	\$1,365,388	
Other Funds	\$0	\$0	\$0	
Program Funds	\$0	\$0	\$0	
SubTotal	\$2,773,690	\$2,788,491	\$2,845,203	
Other Federal Funds	\$1,837,374	\$1,143,527	\$0	
Total	\$4,611,064	\$3,932,018	\$2,845,203	

	2020	
	Budgeted	Expended
Federal Allocation	\$1,488,491	
State Funds	\$0	
Local Funds	\$1,169,459	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$2,657,950	
Other Federal Funds	\$2,924,008	
Total	\$5,581,958	

III.D.1. Expenditures

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 tern

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.

Expenditures are allocated based on the population served and the category of services provided to ensure that we comply with the 30-30-10 requirement. Expenditures are continuously monitored allowing proper assessment of the needs of the populations served. Budgeted funds are distributed according to the federal guidelines with consideration of the behavior of previous year expenditures. Consideration is also given to salary increases due to negotiated union contracts put in place.

Fiscal Year 2017 Expenditures of the State Maintenance of Efforts funds were affected by the impact of hurricanes Irma and Maria. The final quarter of local funds allocated were not fully expended due to the damage on the infrastructure. Communication challenges such as the lack of internet and telephone services delayed the processing of encumbrances as well as payments.

The spending of Title V funds was affected for similar reasons. The inability to encumber funds resulted in an increased unobligated balance. The territory is still recovering from this disaster, however remains resilient and continues to work hard to ensure that funds are spent in accordance to Title V requirements.

FY 18 expenditures including Title V, State & local appropriations and other grant funding demonstrates that the Virgin Islands is committed to providing services to women, children and families of the Virgin Islands Community. The Virgin Islands guarantee that MCH funds are used for the purposes outlined in Title V Section 505 of the Social Security Act. Up to 10% of Title V federal allocation is used to support salaries of the administrative staff; MCH Director, Assistant Director and the Office Manager positions.

The MCH Program allocations have taken into consideration the 30-30-10 requirements established by Title V as reflected in Form 2. In addition, the VI intends to expend 100% of 2018 funds further demonstrating our commitment to allocating resources to ensure that the needs of the VI MCH population is met. The scope and the comprehensiveness of services for the VI's MCH population are fully described and outlined in the FY 2018 report and FY 2020 application.

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

In conjunction with state and other federal funds, Title V funds support an array of programs and initiatives developed to improve the health of VI women, infants, children and youth, including children with special health care needs and their families. Other Grants such as MIECHV support evidence-based home visiting and efforts to

engage women and families into health insurance, interconception health, breastfeeding, parenting support and a range of other supports and services. Funding provided through SAMHSA, the Project Launch Grant that provides early intervention to the 0-8 population to ensure children enter school with the appropriate social, emotional, cognitive and physical skills they need to be successful in their academic environment. The Universal Newborn Hearing Screening and Early Hearing Detection and Tracking Surveillance and Intervention grant augments the statewide newborn hearing screening program and supports enhanced efforts to track newborns lost to follow-up services.

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

III.D.2. 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 \$50,000 for FY 2017. An anticipated increase in the state match is budgeted to cover increases negotiated between the local government and employee unions. Efforts are made to match funds according to the identified needs.

The Virgin Islands Department of Health budget a total of \$2,655,106 for FY 2017. These funds are broken down as follows:

	<u>Amount</u>	<u>Percent</u>
Federal Title V	\$1,470,815	55%
State	\$1,184,291	45 %

Program allocation has taken into consideration the 30/30/10 requirements established by Title V minimum funding requirement for federal funds. A waiver of this requirement is not requested during this budget year. Of the FY 2017 estimated Federal Title V allocation, the allocations are as follows:

Preventive and Primary Care for Children	\$441,244 (30%)
Children with Special Health Care Needs	\$441,244 (30%)
Title V Administrative Costs	\$147,081 (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 payers 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 2017 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.

This FY 2020 budget reflects the Virgin Island's continued commitment to Title V programs and services. The VI will continue to use FY 2020 Title V funds to fully support the implementation of the VI's Title V State Action Plan. Title V funds, in addition to State appropriation, and federal grant funds will continue to support programs and initiatives across all areas as described in the application section. This includes the development of data analyses and reports that will be used to guide the VI's services for the MCH population.

The 2020 budget will support efforts that will promote optimal health, safety and well beings of infants, children and adolescents birth to 21 years through preventative practices and strategies along with a continuum of growth development. Title V will continue to support targeted strategies that will be employed to expand outreach and support our culturally diverse population. Through title V funds, the MCH & CSHCN Program continue to advocate for adolescent patients access to basic level of health care by engaging Providers through survey on the best practice to address the concerns of their adolescent patients and ways to guide their development as independent agents with regard to their health.

The VI will continue to move towards a greater understanding of social emotional development in children and adolescents and promote and support efforts to ensure all VI children have the opportunity for healthy development. Overall efforts will continue to provide supports and services for children and adolescents, with a significant focus on social-emotional development, obesity, teen pregnancy and parenthood, community health workers and services for CSHCN and many other supports and services discussed throughout the application. Partnership with community-based organizations such as Early Head Start, Lutheran Social Services and Preschool Education Programs will continue. Ultimately most important is the promotion of health equity for all.

Financially, the Virgin Islands do not anticipate an increase in Title V funds this year, however due to union negotiated raises; the salary and fringe line item categories will increase. Up to 10% of the budget will be used to administer the grant. As in prior years, the Virgin Islands state share for MCH services will continue to be considerable, and will meet the requirements for state match. Expenditures for FY20 are expected to utilize the full allocation of funds. The VI continues to be fully committed to the health and wellness of all Virgin Islanders and will move forward in the comprehensive work as outlined in the Title V State Action Plan.

III.E. Five-Year State Action Plan

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

State: Virgin Islands

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

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

State Title V Purpose & Design

The Title V MCH & CSHCN Program is administered as one integrated program within the Virgin Islands Department of Health. This allows for better and more efficient coordination of services in MCH. The program provides health care services for mothers, infants, children, youth and adolescents and their families. The program also provides and coordinates a system of preventive and primary health care services for this population. These services include prenatal and high-risk prenatal care clinics, postpartum care, well child care, high risk infant and pediatric clinics, care coordination and access to pediatric sub-specialty care for children and adolescents with special health care needs. Services are provided in accordance with SSA -Title V law related to children with special health care needs.

The MCH & CSHCN Program is guided by an advisory council, which is charged with the responsibility of advising the Administrative Unit of the MCH & CSHCN Program. The Advisory Council assists in developing goals and objectives, long range program planning, identifying service gaps, locating resources, and monitoring the quality of services provided. Members of the Council include representatives from: Family Planning, Departments of Education, Human Services and Justice, Infants and Toddlers, 330-funded health centers, parents and guardians of children with special health care needs, child care providers, hospitals and faith and community-based organizations. The MCH Director, and Assistant Director are ex-officio members. The Advisory Council was revitalized in 2018 in conjunction with the well-established Maternal, Infant, and Early Childhood home visiting Advisory Board. Council members are instrumental in review of program activities and provide valuable input.

Goals & Objectives: MCH & CSHCN goals are: (a) to assure access to comprehensive coordinated, family-centered, culturally-competent primary and preventive health care services for all women and children, especially low income and vulnerable populations, in order to promote and improve pregnancy and birth outcomes; (b) to improve the health of children and adolescents including those with special health care needs through comprehensive, coordinated, family-centered, culturally-competent primary and preventive care; and (c) to provide a system that eliminates barriers and health disparities and strengthens the MCH infrastructure.

Direct Care: The program assures access to preventive and primary health services for infants, young children and adolescents, including allied health and other health related services. Specialty clinics provide pediatric specialty services that are generally unavailable or inaccessible to low-income, uninsured or underinsured families. While the aim of the Prenatal / Perinatal Program is to prevent maternal and infant deaths and other adverse perinatal outcomes by promoting preconceptual health, assuring early entry into prenatal care, and improving perinatal care.

Enabling Services: Issues related to access to care are addressed through provision of comprehensive primary and preventive care for children and adolescents which include access to direct medical care; referrals to support programs and services; and strengthening of Title V collaborative partnerships. The Title V program continues to function as the safety net for families with limited resources. The program remains committed to providing clinical preventive care and case management services for pregnant women, infants and children in low income populations.

Population-based services: The MCH & CSHCN Program offers three population-based preventive services: immunization services; the newborn hearing and loss to follow-up through the Universal Newborn Screening and Intervention Program and genetic / metabolic screening program; and the newborn hearing screening program. Home visiting services are also provided to at risk families through the Maternal, Infant, and Early Childhood home

Visiting Program.

Infrastructure building services: The program continued activities directed at assuring the availability of the infrastructure necessary to delivery of services to the maternal/child population and to increase access to quality health care for families who lack sufficient financial resources to meet the costs of medical care. The State Supplemental Data Initiative grant is structured to drive improvements in data systems for collection, analysis, surveillance and reporting capacity are critical to providing accurate assessments to assure these needs are met and the target population is being served.

Children with Special Health Care Needs

For children, ages 0-21, with disabilities and chronic conditions, the program provides preventative and primary care, therapeutic and rehabilitative services. The MCH & CSHCN program offers a system of family-centered, coordinated, community-based, culturally competent care, assuring access to child health services including medical care, case management and home visiting, screening, referrals and assistance obtaining a medical home. 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 parental counseling and education regarding growth and developmental milestones, proper nutrition practices, immunizations; service / care coordination and home visiting services to high risk children and their families. Children with special health care needs have access to a source of care that provides evaluation and treatment sources; early developmental and hearing screening; early intervention services; care coordination and family support services, and access to clinical and laboratory 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.

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 ASQ 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 sub-specialty clinics by the primary care physician.

MCH & CSHCN Services

MCH & CSHCN remains committed to building an effective system of care through 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.

Personnel shortages continue to hinder the capacity of MCH to provide optimal care on both islands – particularly in St. Croix. Recruitment is underway for a Pediatrician, Pediatric Nurse Practitioner, a Speech Pathologist, Registered Nurses, and Certified Medical Assistants to support our clinical care.

The lack of Pediatric Specialists on island to provide the services needed for children with special health care needs limits the availability of specialty care and remains a challenge, we continue to have discussions with National organizations to facilitate bringing in specialists, as well as exploring the option of telemedicine for MCH. Quarterly pediatric neurology visits resume in 2018 for both districts. MCH continues to partner with the local schools, Head Start and Early Head Start to ensure a coordinated system of care for families in need of services.

III.E.2.b. Supportive Administrative Systems and Processes

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

Title V Workforce Development

The Title V Program continues to be an advocate for professional development. In 2016 Inter-agency trainings were held in each district to cover Child Abuse awareness and Disaster Behavioral Health for MCH and various community partners to include the Departments of Health, Education, Human Services, Justice, Corrections, and local non-profits such as Early Head Start, VI Partners for Healthy Communities and Women's Coalition.

The Zika 101 training which was cancelled due to the advent of the two category 5 hurricanes in 2017 was completed in 2018. Staff also received training on the use of, and gained access to, the database used by the Department of Health's Epidemiology Division to track Zika testing and births. Nursing staff also received an in-service training on pediatric neurology and pediatric development screening instruments such as the ASQ and Denver tools.

Several Title V staff received training in the Use of the OZ newborn hearing screening database in order to fill the gaps in the newborn hearing screening program. Prior to this training, a significant number of newborns were being missed in the hospital or were inadequately followed up in the outpatient setting in order to meet the milestones for the Early Detection Hearing and Intervention program. There was an improvement of the percentage of newborn receiving hearing screening services (85.5%/2018 compared to 81%/2017).

Over the last year, staff received in-service trainings on genetics counseling and Zika, and attended various conferences to aid in professional development from AMCHP, EHDI, MIECHV, and MCHB Federal/State Partnership trainings.

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

Family Partnerships

Role of 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 parents champion the Sickie Celle Associations in the Territory with whom we partner. In line with our commitment towards parent involvement and engagement, the program is working was successful in hiring our first paid family representative in 2018. The following narrative speaks to some of the family partnership activities held over the last year, as told by our Family Representative:

Family Involvement is happening everyday with mothers in our clinics, newborn and regular hearing screening clinics, home visiting, and with your new program Project Launch. Parents are encouraged and invited to attended trainings, workshops, and to join the different special needs councils.

The Department is also involved with Family Voice VI, CDC Ambassador of the Virgin Islands and VI Act Early and VI Developmental Disabilities Council, Inc. As a grandma, I am in two parents' group by phone one with the VI Blind and Deaf out the University of Florida and the other one with Hands of Voices. The support of speaking and hearing each other experiences as been great for my family. So, I am encouraging my parents to join. At the department of health, we have a program by the name Healthy Families Virgin Islands Home Visiting Program, and they have been helpful with your newborn mothers and babies.

Additionally, I have owned and operated a daycare for the past 20 years and I have seen so many challenges that parents and their children have experienced. I made a point to learn and attend child development conferences and other educational efforts so I can assist them as well.

The program provides services for children with special health care needs and works through established formal and informal relationships with other public agencies, academic institutions, and health care facilities. The program also offers national guidance through conferences and workshops which brings to light the challenges and obstacles that are experienced, but at the same time enlightens on the benefits and the rights that are afforded.

Some of those programs we have done are through the EDIH, Family Café, collaboration with community agencies that deals with children with special needs, outreach efforts on the impact of ZIKA on families, work closely with the deaf and blind and other efforts to assist this special population.

At this point, the MCH Program is currently exploring ways to support the implementation of the national Family Voices Organization in the USVI. We have participate in several meetings thus far. This is an area that I am very excited about and look forward to working more jointly with children and parents through the department's mission of providing care and support.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

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. This is achieved through activities that support the creation of an effective data reporting structure that supports the State MCH efforts to effectively gather data through in-house data systems as well as effective linkages to other systems that serve the MCH population. It is the goal of the SSDI to ensure the continued effectiveness and readiness of Title V-supported programs in responding to the changing needs of the nation's MCH population.

The goals of the SSDI program are:

1. Build and expand State MCH data capacity to support Title V program efforts and contribute to data driven decision making in MCH programs. Specific areas in which the SSDI program will assist the State.
2. Support the State's Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality through improved availability and reporting of timely data to inform efforts and track outcomes that drive quality improvement and collaborative learning.
3. Advance the utilization of both the minimum and core data sets (M/CDS) for State Title V MCH programs.

FY18 Updates:

The SSDI program supported the development of the Title V Block Grant Application/Annual report. The SSDI Project Director was successfully retained in calendar year 2018 and participated in the Title V Block Grant review. However, the program suffered significant setbacks in calendar year 2108 because of the two hurricanes which impacted the territory in calendar year 2017. With the main servers being physically housed on the island of St. Thomas, the St. Croix district could not access the electronic systems used to capture services. Even access to the internet was compromised as the two storms individually impacted the two districts. Yet another setback with its data collection efforts due to the resignation of new staff that transferred into the division in the role of data quality specialists. We continue to educate management of the Department of Health on the need to hire and retain data staff to have access to data for decision making. Currently, there are three data staff vacancies. All three vacancies have been approved and are currently being processed. Next steps include posting of the vacancies, interview and selection of successful candidates.

SSDI staff continue to assess Title V performance measures and make recommendations to the Title V Director regarding improvement of the measures and strategies/activities that meet the stated goals. To that end, SSDI supported staff assisted with the review and development of NPMs, SPMs, and ESMs for the Title V Block Grant Application/Annual Report.

Despite an unsuccessful bid as a 2019 MCH Epi Host Site, Title V continues to engage its federal partners and advocates to find solutions which will through other TA opportunities, help to enhance the Epi capacity of Title V.

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

Health Care Delivery System

The Health Care Delivery System in the USVI was greatly impacted by the effects of Hurricanes Irma and Maria in 2017. The Charles Harwood Complex on St. Croix was shut down in 2018, and the Governor Juan F. Luis hospital suffered major damages. JFL struggles to meet the medical needs of population with the displacement of the Emergency Room, one functional operating room at times, limited in-patient services. As a result of damages to the hospital, some units have been scaled back, relocated, and/or combined (the labor and delivery and postpartum wings were combined). The hospital hopes to have their modular units operational by 2020.

Schneider Regional Medical Center, the hospital on St. Thomas that also serves St. John in USVI, has resumed operations for most services. Schneider is able to provide surgery, emergency, and ancillary services such as pharmacy, occupational and physical therapy, nutritional services, and radiology. However, hurricane damage keeps the hospital's 51-bed inpatient unit and its cancer center closed, limiting both inpatient bed capacity and oncological services. The hospital is delivering chemotherapy on an outpatient basis but transporting patients needing radiation to Puerto Rico for treatment. As of late July 2018, all 49 hemodialysis patients who had been medically evacuated from St. Thomas had returned to the island (Kaiser, 2018).

Juan F. Luis Hospital on St. Croix in USVI has two functional operating rooms, down from six, and is able to provide only emergency surgical services a year after the hurricanes. The hospital is in the process of preparing three donated trailers to serve as additional operating units. Due to this limited surgical capacity, non-emergency surgical patients must be transferred to St. Thomas or the continental U.S. for elective procedures. Juan Luis had also evacuated its dialysis patients to the continental U.S. following the storms. As of early September 2018, 21 of these medical evacuees have returned to the island and are receiving treatment from a private provider, while 37 evacuees remain in Atlanta, Georgia. Temporary trailers for dialysis services have faced construction delays but now target a completion date of October 2018 (Kaiser, 2018).

Both Schneider and Juan Luis hospitals are awaiting the outcome of FEMA's assessment of their facilities for either repair or replacement. In the February 2018 Bipartisan Budget Act (BBA), the territories received statutory permission to rebuild "critical services," including hospitals, regardless of their pre-hurricane condition. Under the BBA permission, the USVI hospitals may be able to rebuild to a higher standard than their pre-hurricane facilities if the FEMA assessments call for complete replacement. However, since rebuilding can only commence after a final assessment from FEMA that a facility cannot be repaired, the USVI hospitals have employed short-term mitigation efforts to support delivery of services while they await permanent solutions (Kaiser, 2018).

USVI's clinics vary in operability and capacity. Myrah Keating Smith Community Health Center on St. John, part of the same health system as Schneider Regional Medical Center, was still closed as of July 2018 as it awaits federal assessment of its damage. Patients are receiving services from temporary trailers, although capacity is limited. Frederiksted Health Care, a nonprofit primary care clinic on St. Croix, has resumed delivery of all of its health care services but operates with a smaller staff, particularly for behavioral health and dental services. The clinic reported an increase in overall patients due to the limited capacity of Juan Luis and the outmigration of some private providers. More broadly, the USVI Department of Health has faced challenges delivering public health services such as immunizations, dialysis, and emergency care due to shortages in staff and functional facilities. The Department is continuing work to acquire hard-sided modules as a temporary solution to expand capacity (Kaiser, 2018).

Historical Overview

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 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.

Statutory Authority: The Department of Health functions as both the state regulatory agency and the territorial public health agency for the U.S. Virgin Islands. As set forth by the Virgin Islands Code, Titles 3 and 19, the Department of Health (DOH) has direct responsibility for conducting programs of preventive medicine, including special programs in Maternal and Child Health, Family Planning, Environmental Sanitation, Mental Health, and Drug and Substance Abuse Prevention. DOH also is responsible for health promotion and protection, regulation of health care providers and facilities, and policy development and planning, as well as maintaining the vital statistics for the population.

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

The department employs providers and administrators from every aspect of health care, and manages several programs, both federal and local; to meet the needs of the community it serves. Services are focused towards accomplishing the Department's aim and are administered by 34 activity centers under the following four (4) divisions:

- * Office of the Commissioner
- * Division of Fiscal Affairs
- * Division of Administrative Services and Management
- * Preventative Health Services

The department includes three health care facilities, two district offices and field offices, as well as the central office, located on St. Thomas. Public Health Services and Health Promotion & Statistics reach out to many vulnerable residents, including those suffering from HIV/AIDS, mental illness and alcohol and drug dependency. The Bureau of Health Insurance and Medical Assistance Program assists those who cannot afford to pay for needed medical and prescription services.

DOH is a critical component of the Virgin Islands Territorial Emergency Support Function-8. Under ESF-8, DOH

directs the provision of health services for the Territory in the event of a natural or manmade disaster such as bioterrorism. This role includes coordinating and managing territorial resources to assist victims affected by a disaster.

The overall mission of VIDOH is to reduce health risks, increase access to quality health care and enforce health standards. The five major performance goals guiding the department encompass all legal mandates as spelled out in the V.I. Code. These goals also address the focus areas for achieving the department's mission.

- Improve health outcomes and access to quality health care
- Provide health education, health promotion and community-based programs
- Enhance mental health and substance abuse services
- Achieve excellence in management practices
- Enforce laws and implement rules and regulations

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.

Hospitals: The two public hospitals are under the management of a Territorial Board and two District Boards established under Bill No. 20-0366. The Schneider Regional Medical Center (SRMC) is the umbrella entity for three facilities under one health care system on St. Thomas. The Roy Lester Schneider Hospital (RLSH) is a 169-bed acute care facility located on St. Thomas. Since 1982, it has served the residents of St. Thomas and nearby St. John, St. Croix residents who have required its services, as well as 1.2 million visitors who arrive by air and cruise ships each year. Meeting the health care needs of its community has required constant expansion of medical services, and recruitment of highly qualified and board certified medical professionals. The hospital is a popular provider of choice for the USVI community, and, given the services now offered, it is the convenient option for many patients from throughout the Eastern Caribbean region who are referred here for treatment. As a Joint Commission accredited facility, RLSH is committed to maintaining a superior standard of performance in all areas. Staff education and training are continuous, and an organization-wide focus on coordinated customer service is maintained.

Myrah Keating Smith Health Center: Located on St. John, this center serves as an ambulatory facility. In 1999, management of this facility was turned over to the Roy L. Schneider Hospital and the Hospital's Board. The Center is the island of St. John's only 24-hour outpatient health center that offers primary and preventative care health services. This facility also provides services in women's health, high-risk OB/GYN, well woman examinations including PAP smears, complete pelvic exams, pre and post-natal care, well baby care, immunizations, minor surgery, and community education programs. The facility is staffed to provide many other services, including adult medicine, radiology, ophthalmology, laboratory, and nutrition counseling.

The Charlotte Kimelman Cancer Institute is a patient centered, 24,000 square foot state-of-the-art, comprehensive cancer center which provides a range of comprehensive out-patient diagnostic and treatment services, combining clinical, research, educational, and patient support under one roof. Oncology services include radiation therapy, chemotherapy, and pediatric oncology. CKCI's diagnostic capabilities include Interventional Radiology, Nuclear Medicine, CT Scan, Mammography, and Diagnostic Pathology. CKCI's resources are made available for community use, as well, as part of the strategy to educate the community, and to promote greater public awareness of cancer

prevention and treatment methods.

The Governor Juan F. Luis Hospital and Medical Center, located on St. Croix US. Virgin Islands is a 188 bed facility. As the only full service hospital, it offers acute emergency and ambulatory care in a wide range of services including, general and specialty medicine, surgery, pediatrics, obstetrics, gynecology, psychiatry, physical medicine, hemodialysis and others. The facility is accredited by the joint commission on the accreditation of health care organizations (JCAHO), certified by the Center for Medicare and Medicaid (CMS), a member of good standing with the National Association of Public Hospitals and American Hospitals Association. The hospital pharmacy and blood bank are licensed by the Drug Enforcement Agency and the Pathology and the Clinical lab are also certified by JCAHO.

330-Funded Community Health Centers: An affiliate agreement was signed by the Governor of the Virgin Islands, which placed the governance of the health centers under the authority of governing boards. The health centers are incorporated as not-for-profit entities. Both 330 centers are private corporations independent of the Department of Health.

The Frederiksted Health Center, (FHC), serves approximately 25,000 (USVI 2000 Census tract) on the western side of St. Croix. Adjacent to FHC is the Ingeborg Nesbitt Urgent Care Center (INC), which provides walk-in services to patients of all ages. Critical patients are transferred to the Governor Juan F. Luis Hospital and Medical Center. Laboratory services and pharmaceutical services are provided on site. FHC services include: Family Practice, Family Planning, Prenatal, Pediatrics, Women's Health, Social Services, and Immunizations.

The facility is partially federally funded under a Section 330 Rural Health Initiative and Ryan White Title III - Early Intervention Services Grant Program through the U.S. Public Health Service and partially locally funded through the Virgin Islands Government to provide accessible, quality, primary health care for the people of Frederiksted and the identified surrounding residential areas. The facility serves Medicaid (MAP), Medicare, third party Insurance, self pay and indigent clients.

The St. Thomas East End Medical Center (STEEMC), on St. Thomas, serves the medically under-served population of approximately 24,000 on the heavily populated eastern end of the island. STEEMCC provides a cadre of services for its patients but its main focus is on providing primary and preventive health care. These services include, but are not limited to, medical primary care, walk in services, oral health, psychiatric referrals, HIV testing and counseling, pediatrics and prenatal care, hypertension, cholesterol and diabetes screening and counseling, family planning services, breast and cervical cancer screening and prostate testing. Ob-Gyn care includes gynecological care, prenatal care, antepartum fetal assessment, referral for ultrasounds, genetic counseling and testing, and postpartum care. Oral health care services include preventive, restorative, and emergency based on availability of providers.

Community Health Clinics: The Community Health Centers conduct comprehensive programs of preventive and curative medical care by means of direct clinical services. The St. Thomas Community Health Clinic is located at the Roy Lester Schneider Community Hospital. This clinic provides prenatal, gynecology, family planning services, and pediatric services. On St. Croix, the Community Health Clinic is located at the Charles Harwood Complex. Services include eye clinics, diabetic clinic and primary care for adults. This activity center screens, diagnoses and treats patients with medical problems such as diabetes, hypertension, cardiovascular disease and arthritis. Sub-specialty clinics which provide services in neurology, urology, podiatry, orthopedics, minor surgery, wound management and allergic/dermatologic disease are conducted.

Emergency Medical Services: The Emergency Medical Services (EMS) is the agency charged with the provision of pre-hospital emergency medical care. Inter-island patient transfer services between St. Croix - St. Thomas and Puerto Rico or the continental United States are privately arranged. Patient transfer services between St. John's

Myrah Keating Smith Clinic and St. Thomas Roy Schneider Regional Medical Center are via EMS Ambulance Boat. This agency is responsible for management of the ambulance system, and participates in the delivery of emergency care within the hospital emergency department and the Health Department clinics. EMS provides training for all health care providers, Physicians, Nurses, EMTs and Paramedics. Their training including Pediatric Advanced Life Support (PALS), Advanced Cardiac Life Support (ACLS), Emergency Vehicles Operators Course (EVOC), and Basic Cardiac Life Support courses for the public. The Virgin Islands Emergency Medical Service is a franchise of the American Heart Association.

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

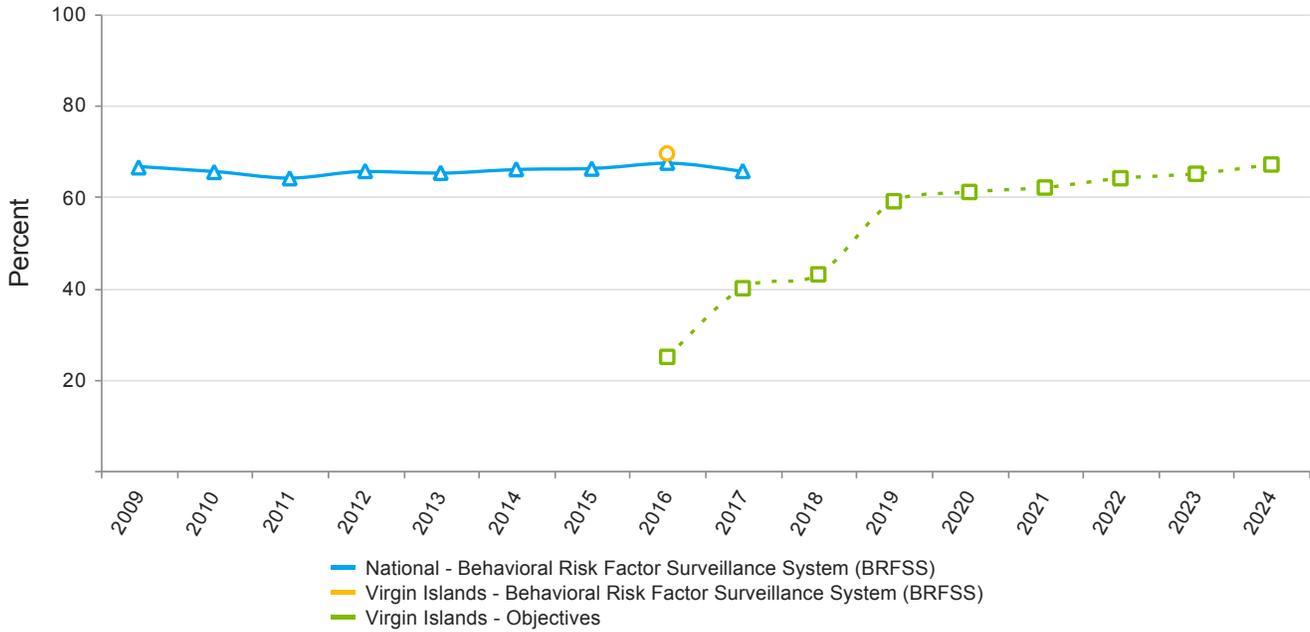
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	9.9 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	10.2 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	32.0 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2011	8.7	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2012	Data Not Available or Not Reportable	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID	Data Not Available or Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	25.4	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures

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



Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2017	2018
Annual Objective	40	43
Annual Indicator	69.3	69.3
Numerator	12,721	12,721
Denominator	18,363	18,363
Data Source	BRFSS	BRFSS
Data Source Year	2016	2016

State Provided Data			
	2016	2017	2018
Annual Objective	25	40	43
Annual Indicator	38.5	55.2	57.9
Numerator	2,275	2,992	2,986
Denominator	5,903	5,419	5,154
Data Source	Family Planning and FQHCs	Family Planning and FQHCs	Fam. Planning and FQHCs
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	59.0	61.0	62.0	64.0	65.0	67.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		41	43	
Annual Indicator	40.6	47.4	87.4	
Numerator	1,087	1,193	1,579	
Denominator	2,677	2,516	1,806	
Data Source	Family Planning	Family Planning	Family Planning	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	89.0	89.0	90.0	90.0	91.0	92.0

State Performance Measures

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			58	
Annual Indicator	57.2	49.9	46.8	
Numerator	667	487	457	
Denominator	1,167	975	976	
Data Source	Hospital Liaison Nurse Report	Hospital Liaison Nurse Report	Hospital Liaison Report	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	50.0	51.0	50.0	52.0	54.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Women/Maternal Health - Entry 1

Priority Need

Increase the number of women that have well women visits

NPM

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

Objectives

Decrease Infant Mortality rate and low birth rate

Improve pregnancy and birth outcomes

Decrease maternal morbidity

Improve overall women's health

Strategies

Increase access to pre-conceptual care for this population by partnering with the Title X to conduct training for providers on sexual health

Improve quality of visit through education on healthy sexual behavior and habits

Partner with Family Planning at least twice annually to support pre-conception efforts through dissemination of health education material on sexual health. This strategy will also include activities which place emphasis on male involvement, family planning responsibility and HIV/STD prevention.

Continue to educate women and their partners about overall physical, emotional, psychological and sexual health and the need for women's health

ESMs

Status

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

Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

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

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

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

Priority Need

Increase the number of women that have well women visits

SPM

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

Objectives

Increase the proportion of pregnant women who receive early and adequate prenatal care.

Strategies

Conduct community-outreach and partner with Home Visiting to reduce barriers and increase access to early and adequate prenatal care that ensures healthy birth outcomes

Women/Maternal Health - Annual Report

Women/Maternal Health

In anticipation of Hurricane Irma's September 6 landfall, St. Thomas SRMC began discharging patients who could be sent home without compromising their health as a precautionary storm measure. SRMC transitioned hospital patients who required continued acute care services to St. Croix for triage and stabilization in an effort to ensure a safe transfer to hospitals and medical facilities in Puerto Rico. In partnership with the Department of Defense, SRMC began medical evacuations to Puerto Rico immediately following Hurricane Irma. However, Puerto Rico's health care services were crippled when Hurricane Maria struck only 14 days later and so were those on St. Croix. Throughout the Territory, the catastrophic interruption of power, Internet, and telecommunications complicated service delivery to patients who remained on-island, as well as the continuity of care for medical evacuees and those who sought refuge on the mainland (Taskforce Report, 2018).

FEMA evacuated the seriously ill and most dialysis patients to various stateside facilities for care. Emergency relief from the federal government, nonprofits and philanthropic organizations poured into the territory to address serious damage to telecommunications, food security, transportation, housing, educational systems, and the economic sector. Due to structural damages at the Community Health Clinic on St. Thomas, prenatal services were moved down to MCH after the storms. The services have since been integrated permanently under MCH on St. Thomas and now mirrors services that were available on St. Croix.

Prenatal Clinic Risk Assessment

All enrolled prenatal clients were assessed initially and throughout their prenatal care for risk factors that can lead to poor pregnancy outcome. Factors assessed include emotional, psychosocial factors and general health status. Risk assessment for post-partum depression, Domestic violence, infant / child care preparedness is assessed on each client. All patients were provided with a planned post-natal care plan that included structural visits which encompasses a 2, 4, and 6 weeks post-delivery evaluations. Sixty-two percent of the client enrolled revealed at risk statuses, which required structured prenatal visits to include counseling on nutrition, psychosocial issues and infant care teaching /support. These services were also provided for the high- risk population to include scheduled visits with the Perinatologist. Disease categories that placed patients in the high-risk status include hypertension, diabetes, thyroid disorders and other disease processes. Seventeen patients were referred and were enrolled in the MCH home visiting program. Graph 3

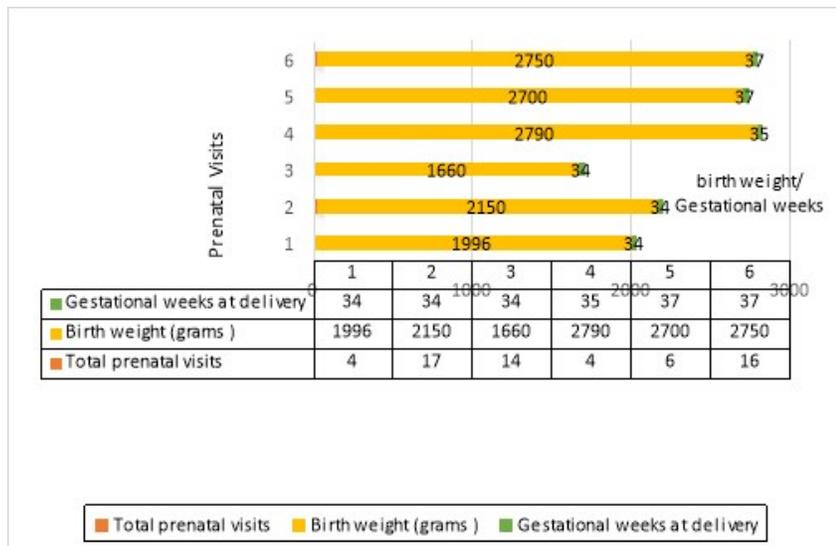


Preterm Delivery Outcome Summary

Six of the 53 clients enrolled in the prenatal program delivered prematurely. (Please note data series reflect 7 infants

due to twin gestation.) Although this group represents a significantly low percentage per total census, all cases were reviewed thoroughly with emphasis on maternal follow up care, preterm infant care, and support services. Premature delivery outcomes were reviewed utilizing a case by case review system to detect indicators and stressors that lead to a preterm delivery. Case review placed emphasis on the total number of prenatal visits, health status including high risk conditions and psychosocial issues. The average mean of gestation among the preterm delivery clients was 35 weeks. The lowest gestation age among this population was 34 weeks. The average mean of preterm delivery birth weight was 1979 grams (4lb 5oz), the lowest was 1660 grams (3lb 10 oz. The average NICU stay was approximately 4 to 8 weeks, no infants were transferred off island for services. The average mean of maternal age was 25 with the lowest age at 18.

Prenatal visits averaged 10 visits among the preterm delivery clients with the highest at 14 visits and the lowest of 4 visits. Third trimester enrollment remains a detrimental factor relating to poor delivery outcome among other factors. Early prenatal care and coordinated prenatal visits can be a preventing factor. Some correlation to poor birth outcomes relating to inadequate prenatal care was evident among three clients. For example, a case review of one client enrolled at 30 weeks with a total of 4 visits subsequently resulted in the delivery of a 34week infant weighing 1996 gms (4lb 6oz). Data review also indicated clients with regular prenatal visits did not prevent a preterm delivery due to other factors during pregnancy (i.e. pre-eclampsia), birth weights averaged Maternal health factors among this group include poor maternal spacing, preeclampsia, multiparity and teenage pregnancy. Pre-existing conditions or other disease processes occurring during pregnancy include gestational diabetes, seizure disorder and depression was assessed among the cases. Graph 4



Women/Maternal Health - Application Year

Areas of focus for MCH program activities in Women's Health remain consistent for FY20. MCH has developed a meaningful relationship with the Chronic Disease Division, activities will include various areas in women's health that can be addressed through collaborative program efforts.

Program activities targeting women's health will continue with the Division of Family Planning, Communicable Disease, Chronic Disease, and other partners under the Department Health and in collaboration with both Federally Qualified Health Centers in the Territory in the following areas:

Increase awareness on choices and consequences as it relates to sexual involvement.

Engage women in taking more responsibility for their health care and encourage pre-conceptual care by targeting the 18-25 year old population.

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

Continue to provide access to comprehensive services, STD counseling and testing, with special counseling for adolescents.

Continue outreach and community education efforts to provide information through print, radio and TV media.

Facilitate group sessions and other activities 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.
- Resume planning for Centering program under MCH
- Address health education campaigns to increase awareness on gestational diabetes
- Continue partnerships with Chronic Disease to include activities promoting smoking cessation, heart health, sickle cell awareness, and intimate partner violence

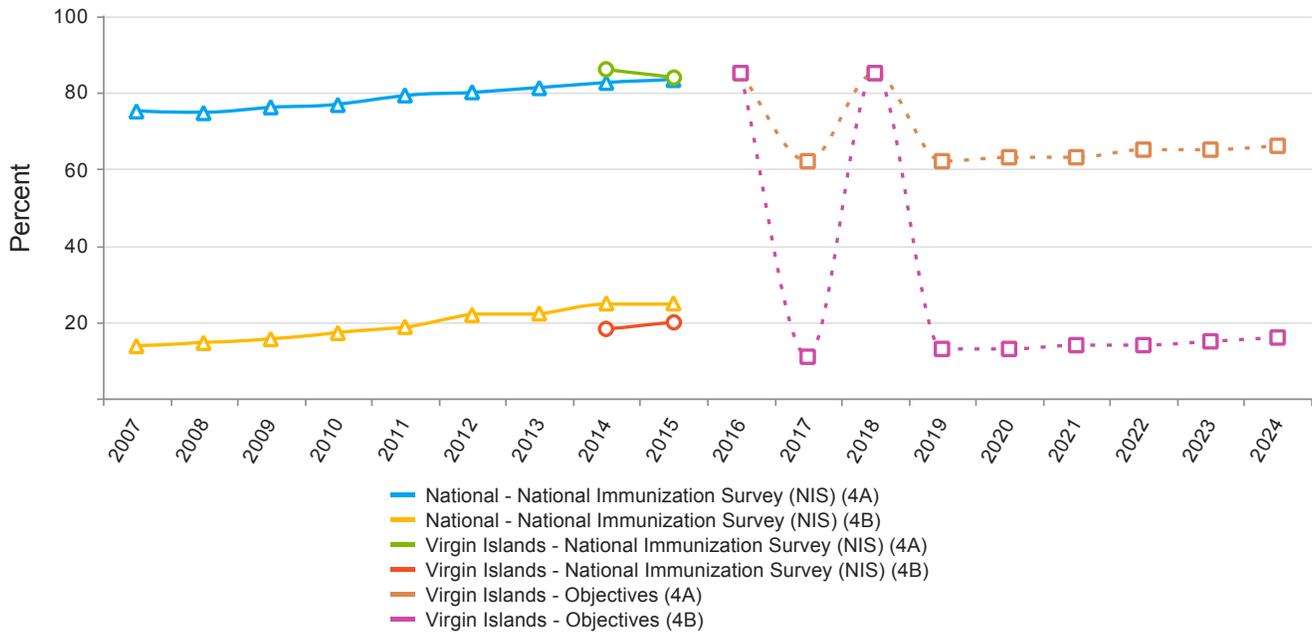
Perinatal/Infant Health

Linked National Outcome Measures

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

National Performance Measures

**NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives**



NPM 4A - Percent of infants who are ever breastfed

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

State Provided Data			
	2016	2017	2018
Annual Objective	85	62	85
Annual Indicator	61.6	50.8	61.2
Numerator	597	423	398
Denominator	969	832	650
Data Source	WIC	WIC	WIC
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	62.0	63.0	63.0	65.0	65.0	66.0

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	85	11	85
Annual Indicator	10.7	13.2	12.2
Numerator	104	110	79
Denominator	969	832	650
Data Source	WIC	WIC	WIC
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	13.0	13.0	14.0	14.0	15.0	16.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percentage of home visitors trained in breastfeeding best practices.

Measure Status:		Inactive - Completed		
State Provided Data				
	2016	2017	2018	
Annual Objective			60	100
Annual Indicator	50	83.3	100	
Numerator	3	5	6	
Denominator	6	6	6	
Data Source	MIECHV Program	MIECHV Program	MIECHV Program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Provisional	Final	

ESM 4.2 - Percent of infants ever breastfed

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	62.0	63.0	63.0	65.0	66.0	

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

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	60	30	80
Annual Indicator	60	80	20.8
Numerator	30	40	5
Denominator	50	50	24
Data Source	MIECHV	MIECHV	MIECHV
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	25.0	25.0	27.0	30.0	32.0

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

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

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	80	20.8
Numerator	40	5
Denominator	50	24
Data Source	MIECHV	MIECHV
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	25.0	25.0	27.0	30.0	32.0

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

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

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	64	20.8
Numerator	32	5
Denominator	50	24
Data Source	MIECHV	MIECHV
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	25.0	25.0	27.0	30.0	32.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Safe sleep education and counseling for WIC and home visiting programs.

Measure Status:		Inactive - Replaced		
State Provided Data				
	2016	2017	2018	
Annual Objective			65	65
Annual Indicator	56.4	56.9	100	
Numerator	75	62	24	
Denominator	133	109	24	
Data Source	MCH Wellness Kiosks	MCH Wellness Kiosk	MIECHV Program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

ESM 5.2 - Percent of families receiving safe sleep educational materials at District birthing hospitals.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	70.0	75.0	78.0	80.0	85.0	

State Action Plan Table

State Action Plan Table (Virgin Islands) - Perinatal/Infant Health - Entry 1

Priority Need

Increase the number of families educated on safe sleep practices

NPM

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

Objectives

Increase the number of families that receive educational information or counseling about safe sleep by 5% each year

Strategies

Educate parents on safe sleep practices at every well-child visit for the first year of life beginning with the post partum visit

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

Provide educational material and training to other Healthcare Providers including the FQHCs and Home Visiting staff on safe sleep practices

Provide training to Child care providers on safe sleep habits

Collaborate with the WIC Program to provide safe sleep education during breastfeeding education classes.

ESMs

Status

ESM 5.1 - Safe sleep education and counseling for WIC and home visiting programs.

Inactive

ESM 5.2 - Percent of families receiving safe sleep educational materials at District birthing hospitals.

Active

NOMs

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

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

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

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

Priority Need

Increase the number of women breastfeeding up to 6 months

NPM

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

Objectives

Increase the mean duration (in weeks) of women breastfeeding at 6 months by 5%

Strategies

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

Facilitate the development of community policies to support breastfeeding in the hospital, workplace, and among health providers.

ESMs

Status

ESM 4.1 - Percentage of home visitors trained in breastfeeding best practices.

Inactive

ESM 4.2 - Percent of infants ever breastfed

Active

NOMs

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

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

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

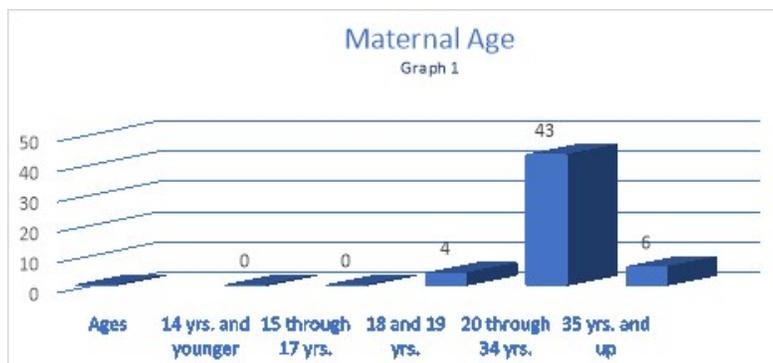
Perinatal/Infant Health - Annual Report

Perinatal/Infant Health

The MCH/CSHCN program continues to provide prenatal services to the prenatal population on both St. Thomas, St. John and St. Croix. This service was directly impacted by hurricanes Irma and Maria. As a result, the St. Thomas Nurse Midwife relocated therefore causing an effect on services provided at the St. Thomas/St. John district. The Perinatologist continues to provide services to our high-risk prenatal population on St. Thomas, St. John and St. Croix.

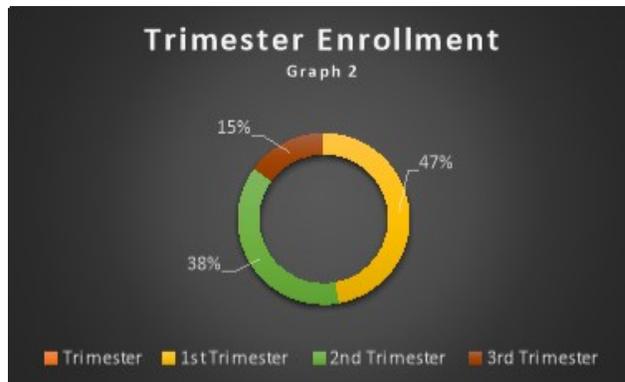
The Maternal Child Health St. Croix District enrolled 53 new clients for prenatal services in 2018. A noted decrease from prior years as services were rendered despite being displaced post storms. Please note enrollment means the number of new patients that entered the program; this does not reflect the numbers of monthly and yearly encounters. On the initial visit all prenatal clients are provided with a history, physical and nursing assessment. Additionally, laboratory studies, diagnostic testing (i.e. Ultrasounds and/or non-stress test are completed) at the recommended intervals. Age group and ethnicity data are also collected and are closely monitored to assess the diversity of the population within the clinical area. Data analysis revealed 4 teenage pregnancies between the ages of 18 -19, 43 clients were between the age of 20 to 34 years and 6 clients were advance maternal age (35 years and older).

Graph 1

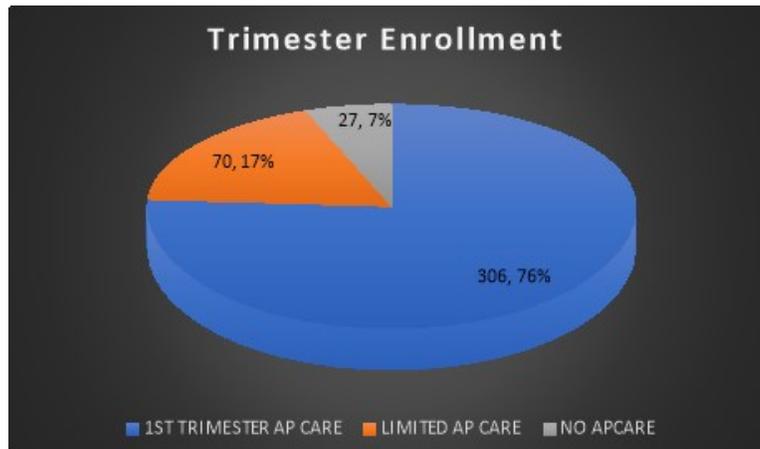


Ethnicity and race demographic data collected on the new enrollees indicated a ninety- two percent predominantly black non-Hispanic clientele and 8% reported race as Caucasian non-Hispanic. Sexually transmitted disease analysis was completed on initial assessment and at various recommended intervals during pregnancy. Clients were screened for gonorrhea, chlamydia and HPV via vaginal smears. Other STD panels evaluated by serum analysis includes RPR, Hepatitis B and HIV. One positive chlamydia was detected and treated; no other infectious disease was detected. Zika was added in 2017 as a prenatal panel for clinical analysis; one positive pregnancy exposure was noted in 2018. The infant was provided with screenings which included a head sonogram, head circumference, eye and hearing analysis. Subsequently the infant was enrolled in the 0- 3 program and the Zika intervention program for careful monitoring.

Forty – seven percent of the newly enrolled clients occurred during the first trimester which remains the optimal goal for early entry into services. Second trimester enrollments were slightly below first trimester enrollments but remain a concern as the goal is early prenatal care to assure successful pregnancy outcomes. Six clients enrolled during the third trimester. Evaluation of these late enrollments revealed transfers from other providers, transient populations and financial challenges. Graph 2



Graph 2A reflects number of total delivered patients on the island of St. Croix that enrolled in the first trimester, received limited AP care, and No AP care. Although the data support a seventy- six percent of all delivered patients received early prenatal care, the data also reflects seven percent of all delivered patients had no prenatal care. Factors that contributed to no prenatal were socioeconomic status, accessibility and transient status.



Prenatal Clinic Delivery Outcomes

Delivery goals and expected outcomes were developed using the American College of Obstetricians and Gynecologist recommendations. The Model focused on providing structured prenatal care at the recommended trimesters encompassing laboratory studies, ultrasound evaluations and non-stress testing. Each client received initial assessments and ongoing assessments focusing on fetal development and wellbeing, nutrition and emotional support throughout pregnancy, delivery and initial infant care. Prenatal clients were scheduled for 18 or more carefully planned visits. Clients are called for follow-up appointments and rescheduled and/ or home visits made to encourage proper coordination and continuity of care. MCH also utilizes the Virgin Islands Perinatal Partnership for counseling, advocacy and assistance with certain economic support. Fifty – seven percent of the enrolled clients delivered vaginally, with optimal birth weights.



Maternal and Preterm Infant Services

The Maternal Child Health prenatal program developed a system of care for antenatal care and preterm infant care. This system is carefully coordinated with the Newborn Nursery Unit at the hospital, home visiting program and the Infant and Toddlers program for all premature deliveries and high-risk conditions during pregnancy. This system is also in place for full term pregnancies and delivery with variation in the referral system based on need or wellness. Once a preterm delivery is eminent the provider is notified by the admitting personnel or physician from the hospital. The providers are provided with client history as it relates the complexity or high-risk factors that results in a preterm birth. Initial delivery care is provided to mother and infant, a referral from the NICU on the status of the infant is provided to the MCH Pediatric Nurse Liaison to begin a plan of care which includes early intervention, newborn genetic testing, nutrition services and pediatric services. Preterm hearing screens are conducted at the hospital and remains on going at the recommended intervals depending on neonatal care history (i.e. antibiotic use etc.).

MCH Pediatric nurses follow babies progress along with early intervention programs (i.e. 0-3 program etc.) Nutrition services is coordinated with WIC services and lactation consultants as a support for preterm infants. Weight checks are completed and tracked by MCH and the WIC program. Post delivery care of mothers include a 2 weeks, 4 weeks and 6 weeks health check on maternal coping factors and antenatal checks for return to post pregnancy stage. These structured visits encompass family coping with new infants, assessments for postpartum depression and infant/ maternal well-being.

Perinatal/Infant Health - Application Year

Program areas of focus for activities in Perinatal-Infant Health continue to remain consistent for FY 20.

- Ensure proper implementation and consistency across districts in prenatal care provided under MCH.
- 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 support 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.
- 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.
- Staff will receive training on Infant Mental Health and Fetal Alcohol Spectrum Disorder to build professional development skills and clinical practice awareness.

Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 6 NPM 8.1 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	11.9 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	Data Not Available or Not Reportable	NPM 8.1

National Performance Measures

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			33
Annual Indicator	100	22.7	53.6
Numerator	30	85	374
Denominator	30	374	698
Data Source	MIECHV	MIECHV	MIECH and Title V Special Pediatrics
Data Source Year	2017	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	53.0	55.0	58.0	60.0	62.0	65.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Interagency committee meetings to support developmental screenings

Measure Status:		Inactive - Completed		
State Provided Data				
	2016	2017	2018	
Annual Objective			3	4
Annual Indicator	2	2		3
Numerator				
Denominator				
Data Source	VI Learn the Signs Committee	VI Learn the Signs Committee	VI Learn the Signs Committee	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

ESM 6.2 - Children receiving a developmental screening using a parent-completed screening tool.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	55.0	58.0	60.0	62.0	65.0	

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			36
Annual Indicator	30.2	30.2	30.2
Numerator	2,484	2,484	2,484
Denominator	8,237	8,237	8,237
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2011_2012	2011_2012	2011_2012
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	32.0	32.0	33.0	33.0	34.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		50	58	
Annual Indicator	49.7	57.3	66.4	
Numerator	1,265	1,787	2,671	
Denominator	2,547	3,120	4,020	
Data Source	FQHC Data	FQHC Data	FQHC and MCH Clinics	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	68.0	70.0	70.0	70.0	72.0	74.0

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

NPM 13.2 - Child Health

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

State Provided Data			
	2016	2017	2018
Annual Objective			57
Annual Indicator	37.8	37.8	45
Numerator	4,116	4,116	7,949
Denominator	10,888	10,888	17,650
Data Source	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS DATA
Data Source Year	2017	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	46.0	48.0	50.0	52.0	54.0	57.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	46.0	48.0	50.0	52.0	54.0	57.0

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Child Health - Entry 1

Priority Need

Decrease the number of children with BMI > 85%

NPM

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

Objectives

Decrease the % of children between the ages of 2yrs to 17 yrs with a BMI > 85% by 5% each year

Strategies

Partner and support FQHC's and WIC efforts in educating families on good nutrition

Continue to promote education within the community utilizing the WE CAN (Ways to Enhance Childhood Activity and Nutrition) program

Encourage discussions about proper nutrition and exercise with all MCH clients.

Utilize the Kiosk, DVDs, Educational materials within the MCH clinics to promote widespread education about the importance of exercise and proper nutrition

ESMs	Status
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ESM 8.1.1 - Physical activity counseling during the well-child visit within the MCH population.	Active
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NOMs

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

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

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

Priority Need

Increase the percent of developmental screenings done in the territory

NPM

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

Objectives

Increase the percent of children that receive developmental screenings during annual visit

Strategies

Standardize the developmental screening that is done in the territory - ASQ testing

Ensure proper training of all staff

Collaborate with Infants and Toddler's program to ensure Early Intervention Services are provided for those that are found to have developmental delays

Continue to participate in DOH, DOE and Early Childhood outreaches to increase possibilities of screening

ESMs

Status

ESM 6.1 - Interagency committee meetings to support developmental screenings

Inactive

ESM 6.2 - Children receiving a developmental screening using a parent-completed screening tool.

Active

NOMs

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

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

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

Priority Need

Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents.

NPM

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

Objectives

Increase percentage of child and adolescent patients receiving a preventative dental visit in the past year.

Strategies

•Develop strategies to increase the number of Dental Providers in the territory through the facilitation of stakeholder input and TA guidance •Increase community awareness regarding the health risks of poor oral health during pregnancy and childhood through social media and community workshops •Partner with FQHCs to provide training and increase education for dental care Providers

ESMs

Status

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

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

NOMs

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

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

Child Health - Annual Report

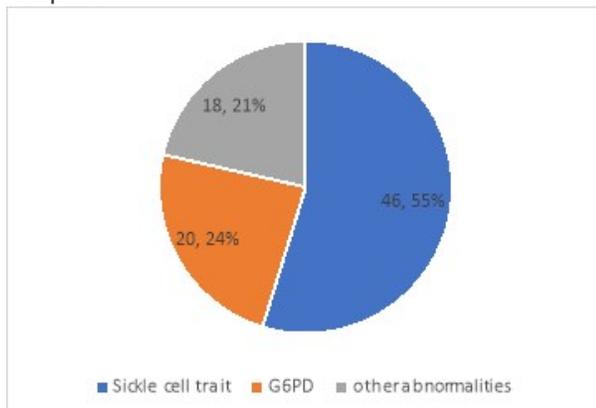
Child Health

The program continued to experience challenges in providing services to the pediatric population due to the impact of hurricanes Irma and Maria well into 2018. System blackouts and infrastructure challenges impacted our facilities and service hours. Immunization services for the pediatric population was transferred to the MCH program in both Districts in July 2018 due budget cuts and program restructuring of the Immunization Program. The program resumed monthly pediatric clinics on St. John in 2018 due to the exigent need and scarcity of services available on the island.

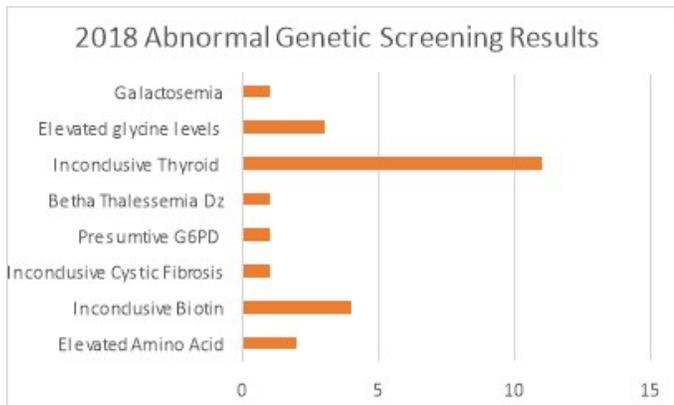
Follow up of the mandatory Newborn Genetic screen and nurse provided genetic counseling for the families of children born with a genetic disorder continues. A total of 568 live births were recorded for the year 2018 in the St. Thomas /St. John district and a total of 408 Newborns received a genetic screen. Because of Hurricane Irma and Maria, many infants were born outside of the territory or relocated to the mainland directly after birth. The relocation of newborns directly affected the outcome of the data collected in the year calendar 2017, contact to connect with those families continued well into 2018. To date, the majority of those have been located, tested, and counseled.

In 2018, a total of 408 infants were born in the district of St. Croix. Of that total 87 infants genetic screen revealed various abnormalities. These abnormalities were followed up with repeat screens if indicated. Genetic counseling and/or referrals to primary care providers were also completed as required. Sickle cell trait and G6PD remains the highest percentage of newborn genetic screen abnormalities. The total newborn screens completed for calendar year was 397 out of 408 births, 5 infants did not receive an initial test at the JFL, reasons for these missed testing include transfer to tertiary NICU. 4 infants were home birth that refused testing at primary care provider and/ or MCH pediatrics. 1 neonatal death. All initial inconclusive results were retested. Of these rescreens formal diagnosis were confirmed revealing one positive Sickle cell disease infant, one Cystic Fibrosis infant and one Thyroid disorder. These children are being seen by primary care providers and specialty care services are coordinated through MCH.

Graph A



Additional abnormal newborns screening results are represented in Graph B below.



MCH worked closely with the Juan F. Luis Hospital and our hearing screeners to implement the following strategies for newborn hearing screens: Appointments are made for re-screen prior to discharge, continuous training, and public awareness (brochures and posters) staff to reinforce the importance of hearing screening follow up. This has been successful. Any newborn missed prior to hospital discharge is quickly identified, the family is contacted through various modalities- phone calls, text, and email. Weekend hearing screening are completed if needed.

The MCH Program provides new moms with baby boxes, baby bags and/or baby changing bags with items donated or purchase by the department. Educational material is included to increase awareness on the EHDI program, and information on topics such as breastfeeding, safe sleep, immunizations, genetic screenings (blood spot), pulse oximetry, and hearing, sign it, text4baby, and Dolly Parton's Imagination Library.

MCH continued it's Adopt-A-School Program in the St. Croix district, MCH nurses collaborate with nurses at the identified school to encourage and facilitate immunization, vision, and hearing checks at the schools with parental consent. Discussions have begun on how best to support school nurses due to the lack of nursing staff at some sites, a lack of supplies, and the high student to nurse ratio in each school.

MCH continues to partner with WIC to support breastfeeding, and nutrition efforts. The Farmer's Market Nutrition Program, in collaboration with the Dept. of Agriculture, which awards checks to WIC participants in order to receive fresh local produce and support local farmers remains successful.

Child Health - Application Year

Areas of focus for MCH program activities in Children's Health remain consistent for FY 20.

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

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 will continue health education and awareness efforts by disseminating brochures on healthy nutritional habits to the clients in the MCH clinics, the FQHCs, schools and at outreach programs.

The MCH program will continue utilizing the kiosks located in the MCH clinics as a self-guided mechanism geared towards educating children and their families about healthy nutrition in a fun and positive manner.

Continue partnering with the WIC program to provide comprehensive education on nutrition and physical activity to include: providing participants education on basic nutrition and importance of physical activity, providing specialized food packages based on individual needs, providing food preparation classes for participants, implementing a plan to address pediatric obesity prevention and management, continue providing clients nutrition assessment, counseling and education at certification individually and in interactive group sessions, 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.

2) 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 AAP endorsed Bright Futures periodicity 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.

Adolescent Health
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	Data Not Available or Not Reportable	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	Data Not Available or Not Reportable	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	Data Not Available or Not Reportable	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 10 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	11.9 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	Data Not Available or Not Reportable	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	38.2 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2016	41.9 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	78.9 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2016	61.3 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	25.4	NPM 10

National Performance Measures

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			71
Annual Indicator	65.2	65.2	65.2
Numerator	6,103	6,103	6,103
Denominator	9,355	9,355	9,355
Data Source	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2011_2012	2011_2012
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	65.0	65.0	67.0	67.0	68.0	68.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Partnerships with school-based health centers to promote adolescent health services.

Measure Status:		Inactive - Completed		
State Provided Data				
	2016	2017	2018	
Annual Objective			1	2
Annual Indicator	0	1	2	
Numerator				
Denominator				
Data Source	Title V Program	Title V Program	Title V Program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

ESM 10.2 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	5.0	8.0	15.0	20.0	25.0	

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

NPM 13.2 - Adolescent Health

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

State Provided Data			
	2016	2017	2018
Annual Objective			38
Annual Indicator	37.8	37.8	45
Numerator	4,116	4,116	7,949
Denominator	10,888	10,888	17,650
Data Source	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS DATA
Data Source Year	2017	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	46.0	48.0	50.0	52.0	54.0	57.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	46.0	48.0	50.0	52.0	54.0	57.0

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

State Performance Measures

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		22	25	
Annual Indicator	22.1	21.1	17.7	
Numerator	2,611	2,492	2,086	
Denominator	11,803	11,803	11,803	
Data Source	MCH and FQHCs	MCH and FQHCs/Community Survey	FQHCs/Community Survey	
Data Source Year	2016	2017	2018/2013	
Provisional or Final ?	Final	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	25.0	26.0	28.0	30.0	31.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Adolescent Health - Entry 1

Priority Need

Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents.

NPM

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

Objectives

Increase access to comprehensive primary and preventive health care for adolescents ages 10-19 years.
Continue outreach activities to parents and schools that encourage annual physical exams for this population.

Strategies

Develop a State Adolescent Health Care Plan in conjunction with DOH, FQHCs, DOE, Parents, and Providers
Continue outreach activities to parents and schools that encourage annual physical exams for this population.
Partner with the schools and FQHCs to provide increased access to students for well child exams for children and youth
Partner with the Family Planning Program to go into the schools and provide a comprehensive adolescent program
Partner with other agencies and Stakeholders to increase Community awareness regarding the needs of the adolescent population
Continue to promote education on wellness to adolescents in the community through outreach

ESMs

Status

ESM 10.1 - Partnerships with school-based health centers to promote adolescent health services.	Inactive
ESM 10.2 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services.	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

Decrease the number of teenage pregnancies

NPM

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

Objectives

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

Continue outreach activities to parents and schools that encourage annual physical exams for this population.

Decrease teenagers that are pregnant by 5%

Strategies

Partner with Family Planning to educate adolescents, families and parents about adolescent sexual health and the need for women's health

Partner with school-based health centers to educate adolescents on healthy sexual habits

Partnering with the FQHC's to increase access and available resources for preconceptual care for the adolescent population (male and female)

Participate in planning activities with the Family Planning Program's teen clinic to address the reduction in unplanned pregnancies among adolescents.

Develop a campaign in Partnership with the Family Planning program and the FQHCs that target adolescents and address the benefits of abstinence.

ESMs

Status

ESM 10.1 - Partnerships with school-based health centers to promote adolescent health services. Inactive

ESM 10.2 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services. Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

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

NPM

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

Objectives

Increase the percentage of children and adolescents receiving a preventative dental visit in the past year.

Strategies

•Develop strategies to increase the number of Dental Providers in the territory through the facilitation of stakeholder input and TA guidance •Increase community awareness regarding the health risks of poor oral health during pregnancy and childhood through social media and community workshops •Partner with FQHCs to provide training and increase education for dental care providers

ESMs

Status

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

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

NOMs

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

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

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

Priority Need

Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents.

SPM

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

Objectives

To assure access to primary care services for adolescents and pre-adolescents ages 10-19 years of age.

Strategies

Improve access to comprehensive, high-quality health care services through the development of a State Adolescent Health Care plan.

Recruit additional member to the advisory committee that represents the interest of adolescent health care.

Adolescent Health - Annual Report

Adolescent Health

Across the territory, program activities and resources focused on the acute and changing needs of the population in the post hurricanes recovery period. Program priorities/activities in Adolescent Health remained consistent in FY18, we aligned our efforts in conjunction with our partner agencies- Family Planning, Community Health, and the Department of Education to reach and meet the needs of this population.

The MCH Program provides access to preventative care for adolescents through our clinics as well as thru various community-based outreach events. In partnership with VI Family Planning Program, activities in school-based settings target adolescent health education in each district.

Adolescence and young adulthood are generally healthy times of life however some important health and social problems either start or peak during these years such as substance abuse and mental disorder. The MCH Program focuses on adolescent health through education. Our providers encourage adolescents by helping them establish healthy behaviors. They stress the importance of physical and mental health. Providers also express the importance of exercise and eating and the important role they both play being healthy. They encourage abstinence among the adolescent population, however, they also stress the importance of practicing safe sex.

MCH partners with the Family Planning Program to expand access and reach to the adolescent population. Outreach activities provide individual and group counseling to adolescents on the importance of parental involvement, healthy decision-making, the value of delaying sexual activity, and resistance skills. Sessions are hosted and supported in the junior high and high schools through Health Outreach Workers and in partnership with Project Promise. Prior outreach events have been held at at Boschulte Elementary School, Cancryn Junior High School, Elena L. Christian Junior High School, John H. Woodson Junior High School, St. Croix Central High School, Ivanna Eudora Kean High School, St. Croix Educational Complex, and the University of the Virgin Islands. School-based educational sessions have reached over 1,000 students in grades 5 through the undergraduate level across St. Thomas, St. Croix and St. John.

St. Croix and St. Thomas each have two public high schools. Adolescents from St. John travel to St. Thomas to attend school. School-based clinics have been hosted at the largest high school on St. Croix since 2010. In 2014, an MOU between the Department of Education and the Department of Health was finalized that established a school-based clinic and regular education sessions at both of the public high schools on St. Thomas. This MOU effectively ensures access to reproductive health education and services for the majority of high school students in the territory, which provides an excellent opportunity to hold these vital conversations with adolescents.

Efforts continue to decrease teen births by providing confidential counseling, exams and contraceptive services within the High Schools in the territory. Teen pregnancy prevention activities are further supported 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.

On the University level, a clinic may be hosted once every two weeks at the St. Thomas campus and once monthly on the St. Croix campus of the University of the Virgin Islands (UVI) during the academic year. The UVI clinic has been ongoing for several years and is an important and firmly established component of the University health system. Approximately 300 students access high quality family planning services through the UVI clinic in past academic years.

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, incompleting 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.

The MCH Program Pediatrician and Home Visiting Nurse Supervisor provide 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 are held at variety of locations such as 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 are distributed to all adolescents that come to the MCH clinics, Family Planning Clinics, the FQHCs, and various outreach programs conducted by the MCH program. All these programs and outreach efforts are 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.

Adolescent Health - Application Year

Areas of focus for MCH Program activities in Adolescent Health continue to remain consistent for FY 20, as program efforts and activities continue to evolve post storms.

Coordinate with the Division of Behavioral Health Division to support the needs of the adolescent population, particularly as a result of the impact of hurricane related trauma.

Seek ways to improve engagement and advocacy among the adolescent population.

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 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.

Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 12

National Performance Measures

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives**

NPM 12 - Children with Special Health Care Needs

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

State Provided Data			
	2016	2017	2018
Annual Objective			31
Annual Indicator	24.9	24.9	24.9
Numerator	212	212	212
Denominator	850	850	850
Data Source	NS-CSHCN	NSCH	NSCH
Data Source Year	2009_2010	2009_2010	2009_2010
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	26.0	26.0	27.0	27.0	28.0

Evidence-Based or –Informed Strategy Measures

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

State Performance Measures

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		80	80	
Annual Indicator	78.2	79.2	71.1	
Numerator	1,167	993	849	
Denominator	1,493	1,254	1,194	
Data Source	MCH Clinic and Allied Health Services	MCH Clinic and Allied Health	MCH Clinic, Allied Health and Medicaid	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	74.0	78.0	80.0	81.0	82.0	83.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Children with Special Health Care Needs - Entry 1

Priority Need

Increase the percentage of families that participate in transition planning

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Increase the number of families for CSHCN that participate in the transition process by 2%

Strategies

Utilize the GOT Transition model to promote family involvement in a structured manner

Educate families on the importance of beginning the transition process by the age of 10 years

Educate Health Care providers on the significance of transitioning families

Participate with other Departments/Divisions in the transitioning process - Voc Rehab, DOE Special Ed, DHS, Community Service Providers, UVI, DD Council

ESMs

Status

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

NOMs

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

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

Priority Need

Increase the percentage of families that participate in transition planning

SPM

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

Objectives

To increase the number of families with CSHCN who are referred to and receive various family support services.

Strategies

Develop community partnerships and increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease; improve health and improve the quality of life.

Children with Special Health Care Needs - Annual Report

Children with Special Health Care Needs

As the community continues to recover from the hurricanes of 2017, the program increasingly has become more accessible and visible throughout the Territory to reach the more vulnerable populations. A number of community-based outreach events were held in 2018. The health vans were deployed, and employees went out to reach families at shopping centers, grocery stores, and schools.

The MCH/CSHCN program also continues to challenge our staff to be committed and to enhance the service we provide to the pediatric population and to the children with special health care needs. This October, we added a pediatric neurologist (on contract) to the providers at the MCH clinic who serves all children of the territory. Our pediatricians have also reevaluated our method of providing care to children with special needs of the territory and has initiated 2 special clinical sessions per month to enhance our services. The diabetic clients meet once per month with the primary pediatricians who through a team effort provides diabetic education. The pediatricians also provide the same opportunity for children with sickle cell disease/traits throughout the St. Thomas/St. John population.

The MCH Adopt-A-School Program collaborated with DOE representatives to conduct school outreach events. Hearing screenings and vaccines were provided at these events with parental consent for Kindergarten and Six Graders. MCH also participated in a hearing screening mission in public schools working with the Bill Clinton Foundation and the American Federation of Teachers. Over 500 children were screened from 5 years to 18 years old. From these screening events, MCH was able to refer children identified as having special health care needs to the Department of Education Office of Special Education for services.

Other efforts to target this population included an outreach (hearing screening and pediatric neuro/developmental screen) with the Early Head Start (48 in the Christiansted location, 24 in the Frederiksted location and 12 receiving home-base services). From this event, over 32 children screened were identified and referred for further Audiology services, the Infants and Toddlers Program, or Education Part B.

The MCH&CSHCN Program continues to provide services to Zika affected families. Nurses made contact with families to schedule appointments for upcoming neurology clinics and worked the FQHCs to obtain available updates regarding patient demographics. Nurses also scheduled meetings with families for updates, field concerns, and coordinate care of families affected by Zika. The MCH Zika program was restructured to focus on three goals: Care Coordination, Transportation, and Telehealth. MCH continues to work the University of Miami's LEND program to support provider education and training for local providers that work with families affected by the Zika virus. In conjunction with the University of Vermont's LEND program, a "Person, Family Centered and Culturally Responsive Care" module was developed and posted on the Mailman Center's website. Learning objectives included:

- Recognizing the family as a constant in the life of a child with a disability.
- Considering the family as the center of decision-making related to their child with a disability and that each family member has strengths and abilities that impact decision making.
- Recognizing the importance of the family voice in every aspect of service from the provision of individual care to program development and evaluation.
- Learning strategies to use when working with families in order to understand a family's perspective
- Understanding the importance of knowing your own biases

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.

MCH is a key partner of the newly formed Virgin Islands Family Voices Chapter. Staff participated in program assessments, key-informant interviews, and family engagement sessions over the last year to support program implementation. Similar to the national standards, the VI Family Voices aims to:

- Develop family and youth leaders, particularly those from underserved and underrepresented populations
- Maintain and strengthen Family Voices' leadership role for children and youth with special health care needs (SHCN) and disabilities through advocacy and partnerships
- Create and support policy positions for children and youth with SHCN and disabilities
- Connect and enhance a vibrant national network of family organizations that reflect the diversity of the population they serve
- Maintain and strengthen organizational structure and capacity

MCH continues activities and partnerships with various community partners such as VI UCEDD, DD Council, Act Early Committee, and the Infants and Toddlers Interagency Council. National collaborations also continued with partners such as Shriners, Mt. Sinai, University of Miami, University of Vermont, and the American Academy of Pediatrics. Shriners conducted their annual visit in each District in 2017 providing orthopedic services to many children in need. The program continues to have ongoing discussions with Mt. Sinai to establish a satellite site in the USVI for pediatric environmental health. Partnerships with LEND institutions in Vermont and Miami to support professional development as well as to build the system of care respectively.

Children with Special Health Care Needs - Application Year

Areas of focus for MCH program activities in Children with Special Health Care Needs remain consistent for FY 20:

The AAP conducted a site visit in July 2017 just prior to the storms as a part of a Technical Assistance request to build and strengthen a system of care for children with special health care needs. Specific goals of this TA request included: 1) Developing a comprehensive and coordinated plan for improving the system of care for children with special health care needs within their medical home, 2) Identifying a system best suited to provide services for unmet health care needs in the United States Virgin Islands, and 3) Coordinating services and supports to meet the needs of the families served. The VI plans to revisit the recommendations that were given as a result of this onsite review of systems, services, and infrastructure.

Develop telehealth capacity on each island under MCH to strengthen the continuity of care, particularly to bridge follow-up consults/services needed to support of children with special health care needs.

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.

Integrate the GOT transition model into our system of care to support the transition of youth with Special Health Care Needs from the age of 9 years while incorporating parent and youth participation in the process.

Cross-Cutting/Systems Building

State Performance Measures

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

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	33.0	34.0	36.0	36.0	40.0

State Action Plan Table

State Action Plan Table (Virgin Islands) - Cross-Cutting/Systems Building - Entry 1

Priority Need

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

SPM

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

Objectives

Increase access to oral health care for children by 5%

Strategies

Develop strategies to increase the number of Dental Providers in the territory through the facilitation of stakeholder input and TA guidance

Increase community awareness regarding the health risks of poor oral health during pregnancy and childhood through social media and community workshops

Partner with FQHCs to provide training and increase education for Pediatric and Prenatal Health Care Providers

Cross-Cutting/Systems Building - Annual Report

Cross Cutting

Oral Health remains a cross cutting area of concern for the USVI. Many families cannot afford the cost of much needed oral health services. Due to the lack of adequate oral health care, common concerns include tooth decay, tooth loss and bone loss. Limited access to care has created waitlists of upwards of one year through our FQHC's. Some private providers accept insurance while many remain out of network due to the reimbursement and application wait times under insurance providers and/or the Medical Assistance Program (MAP).

While a significant portion of the population are Medicaid eligible, there are not enough providers and not enough facilities participating in the territory's Medicaid program, commonly referred to as Medical Assistance Program, or MAP. "A recent report by University of the Virgin Islands researchers, the Community Needs Assessment, said there is a waiting list for Medicaid-backed dental care on St. Croix that is 4,000 people long" (VI Source, 2019). MAP is set up so that a patient on Medicaid must use a public center for general dental care. If the center can't provide what is needed, the patient can be referred to a private dentist, but only after being assessed at the public center.

In 2012, Dental services that were available at clinics administered by the Department of Health were suspended and have not resumed. The Federally Qualified Health Centers (FQHCs) in both districts are the only current public entities providing oral health services. Those services include providing examinations, fluoride applications, fillings and extractions to the children and families who have Medicaid and who are underinsured and uninsured.

At Frederiksted Health Care, Inc. it is estimated that there is a need to cover about 200,000 visits per year. If the centers operate at full capacity every day, the most they can handle is about 18,000 visits (VI Source, 2019). With expansion of the St. Thomas East End Medical Center's dental services facility in 2016, the waiting time for a regular appointment is about five weeks; emergency cases are handled on a same-day basis (VI Source, 2019).

The Charles Harwood Complex on St. Croix was closed after extensive damage resulting from Hurricanes Irma and Maria. Plans to conduct an oral health assessment in partnership with Title V and MCHB were suspended. While the new modular units do not include a dental suite, the Department of Health is in discussions with local partners to determine how best to move forward in meeting the wide range of unmet oral health needs in our population.

Cross-Cutting/Systems Building - Application Year

In June 2019, the U.S. Virgin Islands Dental Association (VIDA) partnered with the American Dental Association (ADA) to convene the U.S. Virgin Islands Oral Health Care Summit, featuring Gov. Albert Bryan Jr. and other elected officials to build upon existing oral health initiatives and address the territory's oral health care needs.

A centerpiece of the plan called for a training program for Community Dental Health Coordinators (CDHCs) at the University of the Virgin Islands. CDHCs work directly with patients in the community to navigate the oral healthcare system and ensure they are receiving the care they need. Serving as an integrated member of the dental team, CDHCs are proven to have a positive impact on both patients and dental practices across the U.S.

The plan also calls for reopening the public dental clinics, as is expected by the Virgin Islands Department of Health, increasing funding for dental services under MAP to increase the number of participating dentists and to reestablish a territorial dental officer in the Department of Health (VI Source, 2019).

The VI MCH & CSHCN Program hopes to add meaningful contributions toward rebuilding a comprehensive system of oral health care. The Division began discussions with the Association of State and Territorial Dental Directors (ASTDD) to conduct an oral health needs assessment in the USVI in the fall of 2018. ASTDD presented to members of the MCH Advisory group on ways to engage and inform key stakeholders in this process. This activity is still underway and will remain a focus for the upcoming year.

III.F. Public Input

The Virgin Islands Department of Health invites public review and input relative to planning for and writing the Title V Five-Year Block Grant Application and Program Plan for the Maternal Child Health & Children with Special Health Care Needs (MCH & CSHCN) Program. Notification on the availability of the block grant application and an invitation to the community to provide comments are made via several modalities: The Department of Health website, local newspapers, social media and public access television stations. Copies of the grant application are also available upon request to agencies and partners.

Response forms accompany each copy with options to accept the application as written or accept with changes and / or additions.

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



GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

**DEPARTMENT OF HEALTH
DIVISION OF CHRONIC DISEASE AND PREVENTION**

Charles Harwood Memorial Complex
St. Croix, US Virgin Islands 00820-4370

Director

(340) 718-1311 Ext. 3700

06/15/2019

Our Advisory Group has reviewed the MCH & CHSCN FY 2020 application/FY 2018 annual report and are in full support of the Maternal and Child Health objective and goals outlined in this application. We are pleased with the increased level of collaboration, particularly in the areas of sickle cell and gestational diabetes. Regarding sickle cell, the advisory board made recommendations regarding the use of funds to support sickle cells activities. The advisory board put forth recommendations to use funds to support workshops, laboratory testing and direct support to families of children with sickle cell. Thus far we have collaborated on family support and community awareness activities.

We have advocated for educating mothers and families regarding gestational diabetes. The Division of Chronic Disease and the MCH team, under the advisement of the board, work collaboratively on chronic diseases that affect women, children and families. Access to primary and preventative health is a measure that speaks directly to chronic disease. Preventive health visits enable the early detection of chronic diseases such as diabetes, cancer asthma etc. Therefore, the application is in alignment with the mission and objectives of the advisory group. We will continue to work collaboratively with MCH to support the deliverables as identified through our population health needs.

The Chronic Disease Prevention Program Advisory Board consists of a multi-disciplinary team of individuals that represent the community and have direct access to the intended recipients of Title V services. The purpose of the Advisory Board is to utilize the input of the population served by the multiple programs represented by the board, to guide the decisions made distribution of funding, and make recommendation on prevention efforts. Please make note of the agencies and community members represented of the Advisory Group by reviewing the membership list. We applaud the MCH Title V effort to meet the needs of the medically underserved population and its collaboration with partners such as our Federally Qualified Health Centers to further broaden the reach of Title V.

Respectfully,

A handwritten signature in blue ink that reads "Kathleen O. Arnold-Lewis".

Kathleen O. Arnold-Lewis, Chairperson of Chronic Disease Prevention Program Advisory Group

Name	Title	Affiliated Organization	Perspective
John Josiah	Community member	Seventh Day Adventist Church	Religious leader perspective in program planning; Male perspective
Yolanda Bryan	First Lady	Office of the Governor	Population Health with an emphasis on Diabetes and Nutrition
Carolyn Forno	Assistant Director	Women's Coalition of St. Croix	Assist with program plan for injury prevention
Esther Ellis	Epidemiologist	Department of Health	Assist with analysis and interpretation of data
Julia Pankey	Community member	None	Retired health educator; Retiree perspective
John Orr	Program Manager	Department of Health	Program planning and data interpretation
Denyce Singleton	Community leader	AARP	Retirement community perspective
Maren Roebuck	Community Member	St. Croix	Promoter of mental and physical health; Experience community outreach work
Janis Valmond	Deputy Commissioner	VI Department of Health	Public Health Services
Judy Ann Ross	Director	Health Services Advisory Group	Quality improvement organization working on cardiovascular initiatives
Clema Lewis	Director	Women's Coalition of St. Croix	Injury prevention work; Non-profit agency
Winifred Anthony-Todman	Counselor/ Program Coordinator	Department of Education	Assist with program planning; Education perspective for program
Lyna Fredericks	Program Manager	Department of Health	Program planning for chronic diseases
Hannifer Britton	Nurse Educator	Juan F. Luis Hospital and Medical Center	Nursing educators perspective in programs
Annette Scott	Community Member	St. Croix	Lends experience in medical technology; Experience in mental health
Anita Joseph	Office Coordinator	Sports, Parks and Recreation	Physical activity part of program planning
Dr. Marc Jerome	Medical Director	Virgin Islands Department of Health	Provider direct care to patients with chronic diseases
Karen Hunt	Program Coordinator	Virgin Islands Partners for Health Communities	Serve clients with chronic disease in non-profit agency
Charlene Navarro	Head Nurse	Frederiksted Health Care, Inc.	Serve clients with chronic disease at Federally

			Qualified Health Center
Michelle Dizon	Internal Medicine Physician	Private/Department of Health	Provides direct care to patients with chronic diseases
Kathleen Renee-Grant	Head Nurse	Department of Health	Nurse that coordinate care of community health clinic patient; Assist w/ program planning
Moleto Smith	CEO	St. Thomas East End Medical Center	Oversees the care of chronic disease patients at Federally Qualified Health Center
Khnuman Simmonds-Esannason	Executive Director	Virgin Islands Domestic Violence and Sexual Assault Council	Injury prevention work; Assist with program plan
Athenia Williams	Clinic Administrator	Department of Health	Assist with program planning and implementation
Darice Plaskett	Chief Nursing Officer	Schneider Regional Medical Center	Hospital nurse leader perspective on program
Gwen Williams	Director	Health Services Advisory Group	Leads quality improvement initiatives for Medicare patients
Gary Smith	Director	Department of Human Services	Directs the services for medical care needed for the underserved population

III.G. Technical Assistance

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.

The Title V/MCH Program aims to increase access to preventative oral health services, particularly for families with low incomes and those with inadequate or no insurance. HRSA approved a Technical Assistance request to 1) complete an initial assessment of dental capacity in the USVI; 2) guide efforts to resume services through process planning and best-practices in re-establishing and maintaining dental services; 3) building capacity through staff training and development in dental prevention; and 4) linking national partnerships for ongoing resources and support. This TA was not delivered due to the 2017 category 5 hurricanes and remains pending.

A request for technical assistance for the Title V Program was approved and implemented in FY 2017. Over the course of three days, the American Academy of Pediatrics (AAP) team participated in dynamic, thoughtful, and honest conversations with key stakeholders. They met with the Title V team, comprised of professionals and parents who are dedicated to improving the system of care for children with special health care needs. Given the variety of services offered and the request to fill the gap created by the cessation of immunization services in the Department of Health, the Title V has an opportunity to leverage scarce resources by filling a gap in the community and providing a one-stop medical service.

Key recommendations provided by the technical assistance effort are that the MCP Program:

- Refine the system of care model with an ecosystem approach - addressing the needs of children and families, providers, health and educational systems, and communities, and the interconnections amongst these entities, (i.e. supportive services in the community--schools, child care centers and clinics-- to meet the specific needs of children with special health care needs).
- Build on the successes of the MIECHV program (specifically identification, support, and referrals) as a model for other MCH programs.
- Refine and streamline data collection strategies (define role of data for individual care coordination and service provision vs. population management.).
- Focus on development of structures process for family involvement for continuous improvement.

The implementation of the approved technical assistance for preventative assistance for oral health services which was delayed due to the impact of Hurricane Irma and Hurricane Maria. This TA effort will be implemented in the upcoming fiscal year.

Technical assistance to support data collection and reporting remains a need for the program. The MCH Program continues to have a need for support on the development of activities to support our needs assessment, analysis and reporting. However, some strides were made in FY2019 with the completion of MCH Epidemiology training for one staff person. Technical assistance needs are being continuously reviewed and addressed to ensure improved capacity of Title V staff.

Technical assistance to support the implementation of a comprehensive Adolescent Healthcare system remains pending.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [IV Title V -Medicaid IAA.pdf](#)

V. Supporting Documents

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

Supporting Document #01 - [Recovery and Health Care post storms.pdf](#)

Supporting Document #02 - [FCC Module for Mailman Center.pdf](#)

Supporting Document #03 - [257521_USVI_HRTR_Health.pdf](#)

Supporting Document #04 - [Medicaid-and-CHIP-in-the-US-Virgin-Islands.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [VI Title V Org Chart 2019_.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Virgin Islands

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

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

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,473,690		\$ 1,488,491	
A. Preventive and Primary Care for Children	\$ 442,107	(30%)	\$ 446,548	(30%)
B. Children with Special Health Care Needs	\$ 442,107	(30%)	\$ 446,548	(30%)
C. Title V Administrative Costs	\$ 147,369	(10%)	\$ 147,369	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,031,583		\$ 1,040,465	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 1,300,000		\$ 1,300,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 1,300,000		\$ 1,300,000	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 1,169,459				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 2,773,690		\$ 2,788,491	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 1,837,374		\$ 1,143,527	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 4,611,064		\$ 3,932,018	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 992,000	\$ 714,323
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 98,774
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Zika Maternal and Child Health Services Program	\$ 500,000	\$ 128,616
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 201,814

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2018
	Column Name:	Annual Report Expended

Field Note:

Upon closure of last year's Block Grant review, discussions were held with internal DOH stakeholders to determine the necessary steps in order to establish a program income account for the MCH Program. These discussions will be revisited under the new administration.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Virgin Islands

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 142,089	\$ 105,314
2. Infants < 1 year	\$ 229,890	\$ 291,177
3. Children 1 through 21 Years	\$ 446,548	\$ 446,548
4. CSHCN	\$ 446,548	\$ 446,548
5. All Others	\$ 75,435	\$ 51,535
Federal Total of Individuals Served	\$ 1,340,510	\$ 1,341,122

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 206,508	\$ 200,215
2. Infants < 1 year	\$ 335,234	\$ 253,234
3. Children 1 through 21 Years	\$ 289,482	\$ 309,134
4. CSHCN	\$ 215,000	\$ 227,746
5. All Others	\$ 123,235	\$ 120,657
Non-Federal Total of Individuals Served	\$ 1,169,459	\$ 1,110,986
Federal State MCH Block Grant Partnership Total	\$ 2,509,969	\$ 2,452,108

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Virgin Islands

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 1,264,642	\$ 1,028,040
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 371,546	\$ 375,550
B. Preventive and Primary Care Services for Children	\$ 446,548	\$ 429,256
C. Services for CSHCN	\$ 446,548	\$ 223,234
2. Enabling Services	\$ 109,424	\$ 229,095
3. Public Health Services and Systems	\$ 114,425	\$ 231,356
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		\$ 95,654
Physician/Office Services		\$ 327,841
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 100,545
Dental Care (Does Not Include Orthodontic Services)		\$ 40,000
Durable Medical Equipment and Supplies		\$ 314,000
Laboratory Services		\$ 150,000
Direct Services Line 4 Expended Total		\$ 1,028,040
Federal Total	\$ 1,488,491	\$ 1,488,491

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 990,329	\$ 990,329
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 453,449	\$ 453,449
B. Preventive and Primary Care Services for Children	\$ 309,134	\$ 309,134
C. Services for CSHCN	\$ 227,746	\$ 227,746
2. Enabling Services	\$ 70,134	\$ 65,547
3. Public Health Services and Systems	\$ 50,523	\$ 55,110
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 93,456
Physician/Office Services		\$ 345,677
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 167,453
Dental Care (Does Not Include Orthodontic Services)		\$ 45,521
Durable Medical Equipment and Supplies		\$ 255,647
Laboratory Services		\$ 82,575
Direct Services Line 4 Expended Total		\$ 990,329
Non-Federal Total	\$ 1,110,986	\$ 1,110,986

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: 976

Data Source Year: 2018

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	903 (92.5%)	68	5	4 (80.0%)

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

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	834 (85.5%)	53	3	3 (100.0%)

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 Screens	416	41	0	0

4. Long-Term Follow-Up

Infants with a confirmed diagnosis are counseled by the MCH nurses and/or pediatrician. The infants are placed in the high-risk MCH clinics and are monitored carefully by the pediatrician and re-referred to the appropriate pediatric specialist. The infants are enrolled in the Infants and Toddlers Program as needed depending on the type of diagnosis. They are carefully monitored through case management.

High-risk clinic covers infants 0-12 months of age. If the infant still has a concern that requires long-term care after one year of age, they are transferred to Special Pediatric Clinic where 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:

Provisional data from Nurse Liaison reports from both District Hospitals.

Field Level Notes for Form 4:

1.	Field Name:	Core RUSP Conditions - Receiving At Least One Screen
	Fiscal Year:	2018
	Column Name:	Core RUSP Conditions
	Field Note:	All children not receiving a genetic screen panel prior to hospital discharge are followed up by Title V staff. The children not receiving genetic testing (70) are followed up with a minimum of telephone calls. Those that do not call or present at the clinic are sent letters. Sixteen letters were mailed. One infant was airlifted out of the territory and subsequently expired.
2.	Field Name:	Core RUSP Conditions - Referred For Treatment
	Fiscal Year:	2018
	Column Name:	Core RUSP Conditions
	Field Note:	Data indicates one confirmed positive that Title V has been unable to locate for follow-up.
3.	Field Name:	Newborn Hearing - Receiving At Least One Screen
	Fiscal Year:	2018
	Column Name:	Other Newborn
	Field Note:	<p>The gap identified by Title V of children born on weekends and holidays has been addressed by training of additional staff to visit the hospital and also follow up on newborns missed in the hospital. The St. Croix district now has three staff that routinely screen and follow up on patients.</p> <p>The number of missed screens has responded positively to this change. Title V staff will continue to work with hospital staff to improve contact data collected so that parents of missed babies can be reached and encouraged to screen in the outpatient setting.</p>

Data Alerts: None

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

State: Virgin Islands

Annual Report Year 2018

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

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	304	41.0	0.0	12.0	47.0	0.0
2. Infants < 1 Year of Age	332	15.0	0.0	1.0	35.0	49.0
3. Children 1 through 21 Years of Age	2,044	37.0	0.0	5.0	58.0	0.0
3a. Children with Special Health Care Needs	78	0.0	0.0	0.0	0.0	100.0
4. Others	11	0.0	0.0	36.0	64.0	0.0
Total	2,691					

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	1,377	Yes	1,377	72	991	304
2. Infants < 1 Year of Age	1,375	Yes	1,375	64	880	332
3. Children 1 through 21 Years of Age	28,855	Yes	28,855	30	8,657	2,044
3a. Children with Special Health Care Needs	Not Available	No	5,973	44	2,628	78
4. Others	77,038	Yes	77,038	11	8,474	11

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2018
	Field Note:	Pregnant Women Total Served
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2018
	Field Note:	Infants Less Than One Year Total Served
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2018
	Field Note:	Children 1 through 21 Years of Age
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2018
	Field Note:	Children with Special Health Care Needs served within the Title V clinics or provided with case management services by Title V social services.
5.	Field Name:	Others
	Fiscal Year:	2018
	Field Note:	Others
6.	Field Name:	Total_TotalServed
	Fiscal Year:	2018
	Field Note:	Total Served

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2018
	Field Note:	This data represents patients within the MCH population, receiving services at multiple service delivery centers in calendar year 2018. This includes the Federally Qualified Health Centers. Services provided exclusively by private providers is not represented in this data.
2.	Field Name:	InfantsLess Than One Year
	Fiscal Year:	2018
	Field Note:	This data represents patients within the MCH population, receiving services at multiple service delivery centers in calendar year 2018. This includes the Federally Qualified Health Centers. Services provided exclusively by private providers is not represented in this data. Title V reach is extensive in this age group because of hearing screen services provided to the newborn population while still in the inpatient setting and follow up in the outpatient setting as needed.
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2018
	Field Note:	This data represents patients within the MCH population, receiving services at multiple service delivery centers in calendar year 2018. This includes the Federally Qualified Health Centers. Services provided exclusively by private providers is not represented in this data.
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2018
	Field Note:	This data represents patients within the MCH population, receiving services at multiple service delivery centers in calendar year 2018. This includes the Federally Qualified Health Centers. The source of this data is the Virgin Islands Medical Assistance insurance program. Therefore, the data is limited to clients participating in the VI Medicaid Program. No federally available data for Children with Special Health Care Needs exists. Children participating in the Medicaid Program make up the Denominator, while children receiving more than three primary care visits in the calendar year or receiving a broad range of specialty services comprise the numerator. The number of children Services provided by private providers is not represented in this data.
5.	Field Name:	Others
	Fiscal Year:	2018
	Field Note:	This data represents patients within the MCH population, receiving services at multiple service delivery centers in calendar year 2018. This includes the Federally Qualified Health Centers. Services provided exclusively by private providers is not represented in this data.

Data Alerts: None

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

State: Virgin Islands

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	976	43	707	145	0	15	0	16	50
Title V Served	976	43	707	145	0	15	0	16	50
Eligible for Title XIX	469	21	339	70	0	7	0	8	24
2. Total Infants in State	1,184	46	868	184	0	15	0	21	50
Title V Served	976	43	707	145	0	15	0	16	50
Eligible for Title XIX	568	22	417	88	0	7	0	10	24

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	2. Total Infants in State
	Fiscal Year:	2018
	Column Name:	Total

Field Note:

This total represents all infants under age 1 served at multiple service delivery centers (to include the FQHCs), and also includes infants born during the last quarter of calendar year 2017 that received services within the MCH population.

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

State: Virgin Islands

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(866) 248-4004	(866) 248-4004
2. State MCH Toll-Free "Hotline" Name	MCH Program	MCH Program
3. Name of Contact Person for State MCH "Hotline"	Lesla McFarlane	Marlene Ostalaza
4. Contact Person's Telephone Number	(340) 718-1311 x3747	(340) 777-8804 x2704
5. Number of Calls Received on the State MCH "Hotline"		0

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	None	
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	doh.vi.gov	doh.vi.gov
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites	None	
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Virgin Islands

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

Name	Derval Petersen, DHed, MAOM
Title	Director
Address 1	3500 Estate Richmond
Address 2	
City/State/Zip	Christiansted / VI / 00820
Telephone	(340) 718-1311
Extension	3787
Email	derval.petersen@doh.vi.gov

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

Name	Derval Petersen, DHed, MAOM
Title	Director
Address 1	3500 Estate Richmond
Address 2	
City/State/Zip	Christiansted / VI / 00820
Telephone	(340) 718-1311
Extension	3787
Email	derval.petersen@doh.vi.gov

3. State Family or Youth Leader (Optional)

Name	Ana Browne
Title	Family Care Coordinator
Address 1	3500 Estate Richmond
Address 2	
City/State/Zip	Christiansted / VI / 00820
Telephone	(340) 718-1311
Extension	3769
Email	ana.browne@doh.vi.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Virgin Islands

Application Year 2020

No.	Priority Need
1.	Increase access to comprehensive primary and preventative health care for adolescents and pre-adolescents.
2.	Increase the percentage of families that participate in transition planning
3.	Increase the number of women that have well women visits
4.	Increase the number of women breastfeeding up to 6 months
5.	Increase access to oral health care for the Maternal and Child population
6.	Decrease the number of children with BMI > 85%
7.	Increase the number of families educated on safe sleep practices
8.	Increase the percent of developmental screenings done in the territory
9.	Decrease the number of teenage pregnancies

Form 9 State Priorities-Needs Assessment Year - 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 10
National Outcome Measures (NOMs)**

State: Virgin Islands

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

Obesity rates among children 0 to 17 are not available. However, where BMI data are available (from the FQHCs), there is a 62% rate of documentation of BMI and Counseling among patients aged 3 to 17.

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

- 🚫 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	522.5
Numerator	51
Denominator	976
Data Source	Gov. Juan F. Luis and Schneider Regional Hospitals
Data Source Year	2018

NOM 2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	976
Data Source	Gov. Juan Luis and Schneider Regional Hospitals
Data Source Year	2018

NOM 3 - Notes:

No maternal deaths reported for calendar year 2018.

Data Alerts:

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

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

- 🚫 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

- 🚫 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

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

Data Source: CMS Hospital Compare

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

Legends:
 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
2016	NR 	NR 	NR 	NR 
2015	NR 	NR 	NR 	NR 
2012	8.5 	2.5 	12 	1,415 
2011	8.0 	2.3 	12 	1,491 
2010	9.4 	2.4 	15 	1,600 
2009	7.1 	2.1 	12 	1,687 

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - 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
2016	NR 	NR 	NR 	NR 
2015	NR 	NR 	NR 	NR 
2012	NR 	NR 	NR 	NR 
2011	NR 	NR 	NR 	NR 
2010	NR 	NR 	NR 	NR 
2009	NR 	NR 	NR 	NR 

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	976
Data Source	Hospital Report-Juan Luis and Schneider Regional
Data Source Year	2018

NOM 10 - Notes:

None

Data Alerts:

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

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	976
Data Source	Liaison Report-Juan Luis and Schneider Regional
Data Source Year	2018

NOM 11 - Notes:

None

Data Alerts:

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

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

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

NOM 12 - Notes:

None

Data Alerts: None

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

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	45.0
Numerator	7,949
Denominator	17,650
Data Source	FQHC UDS Data
Data Source Year	2018

NOM 14 - Notes:

Data for age categories for NOM 14 is not available. UDS data for oral exams, all adults and children, has been substituted for this measure. There may be some overlap between the data presented by the FQHCs for oral exams, prophylaxis and sealants.

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

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

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

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	1.9
Numerator	440
Denominator	23,012
Data Source	National Survey of Childrens Health
Data Source Year	2009-2010

NOM 17.2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.9
Numerator	200
Denominator	23,044
Data Source	NSCH
Data Source Year	2011_2012

NOM 17.3 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	1.9
Numerator	440
Denominator	23,012
Data Source	NSHC
Data Source Year	2011_2012

NOM 17.4 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	24.9
Numerator	226
Denominator	909
Data Source	NSCH
Data Source Year	2011_2012

NOM 18 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	81.5
Numerator	21,937
Denominator	26,933
Data Source	NSCH
Data Source Year	2011_2012

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	11.9 %	0.8 %	216	1,816
2012	12.9 %	0.7 %	275	2,138
2010	12.4 %	0.7 %	259	2,093
2008	15.4 %	0.9 %	262	1,703

Legends:

-  Indicator has a denominator <50 or a relative standard error ≥30% 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, ages 0 through 17, without health insurance

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

State Provided Data	
	2018
Annual Indicator	27.0
Numerator	6,286
Denominator	23,253
Data Source	Virgin Islands Community Survey
Data Source Year	2013

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	45.8 %	3.8 %	841	1,839
2015	50.7 %	3.4 %	992	1,956
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

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Flu

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

Legends:

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

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	41.9 %	2.9 %	3,030	7,240
2015	37.9 %	2.7 %	2,738	7,230

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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) - Teen

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

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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) - Teen

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

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.8
Numerator	2
Denominator	263
Data Source	VI Medicaid Program
Data Source Year	2018

NOM 24 - Notes:

The limitation for this data is that it represents the Medicaid population only. Data for this NOM was requested of and received from the Virgin Islands Medicaid Program for calendar year 2018.

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)
State: Virgin Islands

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

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2017	2018
Annual Objective	40	43
Annual Indicator	69.3	69.3
Numerator	12,721	12,721
Denominator	18,363	18,363
Data Source	BRFSS	BRFSS
Data Source Year	2016	2016

State Provided Data			
	2016	2017	2018
Annual Objective	25	40	43
Annual Indicator	38.5	55.2	57.9
Numerator	2,275	2,992	2,986
Denominator	5,903	5,419	5,154
Data Source	Family Planning and FQHCs	Family Planning and FQHCs	Fam. Planning and FQHCs
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	59.0	61.0	62.0	64.0	65.0	67.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

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

State Provided Data			
	2016	2017	2018
Annual Objective	85	62	85
Annual Indicator	61.6	50.8	61.2
Numerator	597	423	398
Denominator	969	832	650
Data Source	WIC	WIC	WIC
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	62.0	63.0	63.0	65.0	65.0	66.0

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	85	11	85
Annual Indicator	10.7	13.2	12.2
Numerator	104	110	79
Denominator	969	832	650
Data Source	WIC	WIC	WIC
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	13.0	13.0	14.0	14.0	15.0	16.0

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	60	30	80
Annual Indicator	60	80	20.8
Numerator	30	40	5
Denominator	50	50	24
Data Source	MIECHV	MIECHV	MIECHV
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	25.0	25.0	27.0	30.0	32.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

The information reported for this performance measure is collected solely from the MIECHV program. The denominator represents the portion of total children served who were under the age of one in 2018. The numerator represents the number of those children whose parent answered affirmatively to a question that the child slept on an approved surface, without soft objects or loose bedding and on their backs.

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

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

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	80	20.8
Numerator	40	5
Denominator	50	24
Data Source	MIECHV	MIECHV
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	25.0	25.0	27.0	30.0	32.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

The information reported for this performance measure is collected solely from the MIECHV program. The denominator represents the portion of total children served who were under the age of one in 2018. The numerator represents the number of those children whose parent answered affirmatively to a question that the child slept on an approved surface, without soft objects or loose bedding and on their backs.

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

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

State Provided Data		
	2017	2018
Annual Objective		
Annual Indicator	64	20.8
Numerator	32	5
Denominator	50	24
Data Source	MIECHV	MIECHV
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	25.0	25.0	27.0	30.0	32.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

The information reported for this performance measure is collected solely from the MIECHV program. The denominator represents the portion of total children served who were under the age of one in 2018. The numerator represents the number of those children whose parent answered affirmatively to a question that the child slept on an approved surface, without soft objects or loose bedding and on their backs.

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			33
Annual Indicator	100	22.7	53.6
Numerator	30	85	374
Denominator	30	374	698
Data Source	MIECHV	MIECHV	MIECH and Title V Special Pediatrics
Data Source Year	2017	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	53.0	55.0	58.0	60.0	62.0	65.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

The population of children receiving developmental screening increased significantly with the addition of a contracted neurologist within Title V clinics. Title V simultaneously adapted the best practice of providing developmental screening to all children in the appropriate age group regardless of visit type.

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			36
Annual Indicator	30.2	30.2	30.2
Numerator	2,484	2,484	2,484
Denominator	8,237	8,237	8,237
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2011_2012	2011_2012	2011_2012
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	32.0	32.0	33.0	33.0	34.0

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			71
Annual Indicator	65.2	65.2	65.2
Numerator	6,103	6,103	6,103
Denominator	9,355	9,355	9,355
Data Source	NSCH	NSCH	NSCH
Data Source Year	2011_2012	2011_2012	2011_2012
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	65.0	65.0	67.0	67.0	68.0	68.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

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

State Provided Data			
	2016	2017	2018
Annual Objective			31
Annual Indicator	24.9	24.9	24.9
Numerator	212	212	212
Denominator	850	850	850
Data Source	NS-CSHCN	NSCH	NSCH
Data Source Year	2009_2010	2009_2010	2009_2010
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	26.0	26.0	27.0	27.0	28.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health
Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2016	2017	2018
Annual Objective			57
Annual Indicator	37.8	37.8	45
Numerator	4,116	4,116	7,949
Denominator	10,888	10,888	17,650
Data Source	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS DATA
Data Source Year	2017	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	46.0	48.0	50.0	52.0	54.0	57.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Data for age categories for NPM 13.2 is not available. UDS data for oral exams, all adults and children, has been substituted for this measure.
2.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Data for age categories for NPM 13.2 is not available. UDS data for oral exams, all adults and children, has been substituted for this measure. There may be some overlap between the data presented by the FQHCs for oral exams, prophylaxis and sealants.

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			38
Annual Indicator	37.8	37.8	45
Numerator	4,116	4,116	7,949
Denominator	10,888	10,888	17,650
Data Source	FQHC UDS DATA	FQHC UDS DATA	FQHC UDS DATA
Data Source Year	2017	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	46.0	48.0	50.0	52.0	54.0	57.0

Field Level Notes for Form 10 NPMs:

- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Data for age categories for NPM 13.2 is not available. UDS data for oral exams, all adults and children, has been substituted for this measure.
- Field Name:** 2018

Column Name: State Provided Data

Field Note:
Data for age categories for NPM 13.2 is not available. UDS data for oral exams, all adults and children, has been substituted for this measure. There may be some overlap between the data presented by the FQHCs for oral exams, prophylaxis and sealants.

**Form 10
State Performance Measures (SPMs)**

State: Virgin Islands

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			58	
Annual Indicator	57.2	49.9	46.8	
Numerator	667	487	457	
Denominator	1,167	975	976	
Data Source	Hospital Liaison Nurse Report	Hospital Liaison Nurse Report	Hospital Liaison Report	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	50.0	51.0	50.0	52.0	54.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			80	80
Annual Indicator	78.2	79.2	71.1	
Numerator	1,167	993	849	
Denominator	1,493	1,254	1,194	
Data Source	MCH Clinic and Allied Health Services	MCH Clinic and Allied Health	MCH Clinic, Allied Health and Medicaid	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	74.0	78.0	80.0	81.0	82.0	83.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		22	25	
Annual Indicator	22.1	21.1	17.7	
Numerator	2,611	2,492	2,086	
Denominator	11,803	11,803	11,803	
Data Source	MCH and FQHCs	MCH and FQHCs/Community Survey	FQHCs/Community Survey	
Data Source Year	2016	2017	2018/2013	
Provisional or Final ?	Final	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	25.0	26.0	28.0	30.0	31.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

Annual indicator is derived by a numerator which includes MCH and FQHC data divided by a denominator derived by the Virgin Islands Community Survey (census).

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

Measure Status:				Active		
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	33.0	34.0	36.0	36.0	40.0

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)
State: Virgin Islands

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			41	43
Annual Indicator	40.6	47.4	87.4	
Numerator	1,087	1,193	1,579	
Denominator	2,677	2,516	1,806	
Data Source	Family Planning	Family Planning	Family Planning	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	89.0	89.0	90.0	90.0	91.0	92.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Percentage of home visitors trained in breastfeeding best practices.

Measure Status:		Inactive - Completed		
State Provided Data				
	2016	2017	2018	
Annual Objective			60	100
Annual Indicator	50	83.3	100	
Numerator	3	5	6	
Denominator	6	6	6	
Data Source	MIECHV Program	MIECHV Program	MIECHV Program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Provisional	Final	

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Healthy Families America and Nurse Family Partnership staff have all received training on best practices of breast feeding.

ESM 4.2 - Percent of infants ever breastfed

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	62.0	63.0	63.0	65.0	66.0	

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - Safe sleep education and counseling for WIC and home visiting programs.

Measure Status:		Inactive - Replaced		
State Provided Data				
	2016	2017	2018	
Annual Objective			65	65
Annual Indicator	56.4	56.9	100	
Numerator	75	62	24	
Denominator	133	109	24	
Data Source	MCH Wellness Kiosks	MCH Wellness Kiosk	MIECHV Program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Wellness Kiosk have not been in service since 2017 when 2 category 5 hurricanes hit the territory in the month of September. Therefore, this measure represent the MIECHV program data only. A new strategy for safe sleep education was created and implemented. See ESM 5.2

ESM 5.2 - Percent of families receiving safe sleep educational materials at District birthing hospitals.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	70.0	75.0	78.0	80.0	85.0	

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - Interagency committee meetings to support developmental screenings

Measure Status:		Inactive - Completed		
State Provided Data				
	2016	2017	2018	
Annual Objective			3	4
Annual Indicator	2	2	3	
Numerator				
Denominator				
Data Source	VI Learn the Signs Committee	VI Learn the Signs Committee	VI Learn the Signs Committee	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:
New measure developed. See ESM 6.2

ESM 6.2 - Children receiving a developmental screening using a parent-completed screening tool.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	55.0	58.0	60.0	62.0	65.0	

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		50	58	
Annual Indicator	49.7	57.3	66.4	
Numerator	1,265	1,787	2,671	
Denominator	2,547	3,120	4,020	
Data Source	FQHC Data	FQHC Data	FQHC and MCH Clinics	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	68.0	70.0	70.0	70.0	72.0	74.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

MCH clinics were added to the data source for calendar year 2018. Both the population and performance improved. We will be monitoring to observe trend data on the reported levels of physical activity and BMI levels.

ESM 10.1 - Partnerships with school-based health centers to promote adolescent health services.

Measure Status:		Inactive - Completed		
State Provided Data				
	2016	2017	2018	
Annual Objective			1	2
Annual Indicator	0	1	2	
Numerator				
Denominator				
Data Source	Title V Program	Title V Program	Title V Program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

The Title V Program has adopted three schools in the last calendar, with plans to adopt an additional two schools, assisting the school nurses with screening and immunizations.

ESM 10.2 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services.

Measure Status:				Active	
Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	5.0	8.0	15.0	20.0	25.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	Annual Objective

Field Note:

No baseline established. The Title V Program has adopted three schools in the last calendar, with plans to adopt an additional two schools, assisting the school nurses with screening and immunizations. The number of children served at the end of calendar year 2019 will be used to determine the baseline.

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

- Field Name:** 2017

Column Name: State Provided Data

Field Note:
 Although evidence-based transition tool was selected to be recommended for use in public health and FQHCs, the initial discussions are still pending. Thereafter, implementation will take place. Title V will work to support the implementation in public health and FQHCs.
- Field Name:** 2018

Column Name: State Provided Data

Field Note:
 Although evidence-based transition tool was selected to be recommended for use in public health and FQHCs, the initial discussions are still pending. In calendar year 2018, the focus for public health and FQHCs was that of recovery and the provision of basic healthcare services. Title V will renew its efforts to ensure the use of evidence-based transitional care in the MCH population through the adaptation of and evidence-based tool.

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

Measure Status:				Active		
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	46.0	48.0	50.0	52.0	54.0	57.0

Field Level Notes for Form 10 ESMs:

None

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

In partnership with the Association of State and Territorial Dental Directors, Title V will be conducting an oral health needs assessment of existing oral health services to determine capacity and unmet needs.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Virgin Islands

SPM 1 - Increase the percentage of pregnant women who enroll in prenatal care in the first trimester.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active								
Goal:	Reduce barriers and increase access to early and adequate prenatal care that ensures healthy birth outcomes.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of women receiving early and adequate prenatal care in the first trimester.</td> </tr> <tr> <td>Denominator:</td> <td>Number of singleton births.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of women receiving early and adequate prenatal care in the first trimester.	Denominator:	Number of singleton births.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of women receiving early and adequate prenatal care in the first trimester.								
Denominator:	Number of singleton births.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	16.6 The proportion of pregnant women who receive early and adequate prenatal care. 16.6a Care beginning in the first trimester of pregnancy. 16.6b Early and adequate prenatal care.								
Data Sources and Data Issues:	Hospital Labor & Delivery Units; Newborn Nurseries; Bureau of Health Statistics live birth records; MCH, FQHC and Community Health Prenatal Clinics.								
Significance:	Access to early and adequate prenatal care results in improved birth outcomes if women begin receiving care early in pregnancy and continue to receive care throughout the pregnancy. Prenatal care provides an opportunity to identify risks and minimize or eliminate their impact on pregnancy outcomes through medical management so it does not negatively impact on maternal health, birth outcomes and the process of birth. Prenatal visits also offer an opportunity for education and counseling on proper nutrition and risk factors, such as smoking and alcohol use during pregnancy.								

SPM 2 - The percent of CSHCN clients who access family support services.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active								
Goal:	To increase to 50% the number of families with CSHCN who are referred to and receive various family support services.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of CSHCN clients ages 0-21 years whose families access family support services.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of CSHCN clients served.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of CSHCN clients ages 0-21 years whose families access family support services.	Denominator:	Total number of CSHCN clients served.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of CSHCN clients ages 0-21 years whose families access family support services.								
Denominator:	Total number of CSHCN clients served.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	7.7 Patient and family education . Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease;improve health and improve the quality of life.								
Data Sources and Data Issues:	VIDOH EHR, MCH & CSHCN clinic records. Community Health Centers. Community based family support organizations and the Dept of Human Services.								
Significance:	Family service agencies and interagency coordinating councils have identified major challenges confronting families with CSHCN in accessing coordinated health and related services. Addressing these issues will lead to more efficient use of public funds and reduce family stress. Included in community-based settings are public facilities; local government and agencies; and social service, faith, and civic organizations that provide access to families where they live, work, and play.								

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

Population Domain(s) – Adolescent Health

Measure Status:	Active								
Goal:	To assure access to primary care services for adolescents and pre-adolescents ages 10-19 years of age.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of adolescents and pre-adolescents age 10-19 years with a specific source of primary care.</td> </tr> <tr> <td>Denominator:</td> <td>Number of adolescents and pre-adolescents age 10-19 years.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of adolescents and pre-adolescents age 10-19 years with a specific source of primary care.	Denominator:	Number of adolescents and pre-adolescents age 10-19 years.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of adolescents and pre-adolescents age 10-19 years with a specific source of primary care.								
Denominator:	Number of adolescents and pre-adolescents age 10-19 years.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	<p>1. Improve access to comprehensive, high-quality health care services. Access to care depends in part on access to an ongoing source of care. People with a usual source of health care are more likely than those without a usual source of care to receive a variety of preventive health care services A primary care provider deals with all common health needs (comprehensiveness) and coordinates health care services, such as referrals to specialists. Evidence suggests that first contact care provided by an individual's primary care provider leads to less costly medical care. 1.4 Increase in Persons With Specific Source of Ongoing Care</p>								
Data Sources and Data Issues:	MCH, Community Health and 330 FQHC's clinic utilization data. Data issues related to lack of data linkages between provider facilities and standardized methods of data collection and reporting.								
Significance:	A usual source of primary care helps people clarify the nature of their health problems and can direct them to appropriate health services, including specialty care.[44] Primary care also emphasizes continuity, which implies that individuals use their primary source of care over time for most of their health care needs.								

SPM 4 - Increase access to oral health care services for the child and adolescent MCH populations.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active								
Goal:	Increase percentage of children and adolescents receiving preventative oral healthcare services by 5%.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Children and adolescents, ages 1-17 that access care at FQHC dental clinics</td> </tr> <tr> <td>Denominator:</td> <td>Total number of children and adolescents ages 1-17</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Children and adolescents, ages 1-17 that access care at FQHC dental clinics	Denominator:	Total number of children and adolescents ages 1-17	Unit Type:	Percentage	Unit Number:	100
Numerator:	Children and adolescents, ages 1-17 that access care at FQHC dental clinics								
Denominator:	Total number of children and adolescents ages 1-17								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	Reduce the proportion of children and adolescents with untreated dental decay								
Data Sources and Data Issues:	FQHC clinics, UDS Report								
Significance:	<p>1</p> <p>The health of the teeth, the mouth, and the surrounding craniofacial (skull and face) structures is central to a person’s overall health and well-being. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person’s ability to access oral health care is associated with factors such as education level, income, race, and ethnicity.</p> <p>1 Healthy People 2020</p>								

Form 10
State Outcome Measure (SOM) Detail Sheets
State: Virgin Islands

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Virgin Islands

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

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

Measure Status:	Active									
Goal:	To increase the percent of women receiving preconception services through family planning clinics.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of women receiving preconception services through family planning clinics in the past year.</td> </tr> <tr> <td>Denominator:</td> <td>Number of women accessing services through family planning clinics.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of women receiving preconception services through family planning clinics in the past year.	Denominator:	Number of women accessing services through family planning clinics.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of women receiving preconception services through family planning clinics in the past year.									
Denominator:	Number of women accessing services through family planning clinics.									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Community Health Clinic; Family Planning Clinics									
Significance:	<p>A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women’s health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women’s preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.</p>									

ESM 4.1 - Percentage of home visitors trained in breastfeeding best practices.

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

Measure Status:	Inactive - Completed	
Goal:	Increase number of home visitors trained in breastfeeding best practices.	
Definition:	Numerator:	Home visitors trained on breastfeeding best practices in the past year
	Denominator:	MIECHV home visitors
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	MIECHV Program	
Significance:	<p>Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.</p>	

ESM 4.2 - Percent of infants ever breastfed

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

Measure Status:	Active								
Goal:	To increase through education on the benefits of breastfeeding, the percentage of infants who are ever breastfed.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>544</td> </tr> <tr> <td>Denominator:</td> <td>640</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	544	Denominator:	640	Unit Type:	Percentage	Unit Number:	100
Numerator:	544								
Denominator:	640								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	WIC Infants								
Significance:	<p>Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma.</p> <p>American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. Pediatrics. 2012 Mar;129(3):e827-41.</p> <p>http://pediatrics.aappublications.org/content/early/2012/02/22/peds.2011-3552</p>								

ESM 5.1 - Safe sleep education and counseling for WIC and home visiting programs.

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

Measure Status:	Inactive - Replaced	
Goal:	Increase percent of WIC participants and home visiting clients that received safe sleep counseling.	
Definition:	Numerator:	WIC participants and MIECHV clients that received safe sleep counseling in the past year.
	Denominator:	WIC participants and MIECHV clients.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	WIC Program; MIECHV Program	
Significance:	<p>Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the AAP has long recommended the back (supine) sleep position. However, in 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Among others, additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.</p>	

**ESM 5.2 - Percent of families receiving safe sleep educational materials at District birthing hospitals.
 NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

Measure Status:	Active								
Goal:	To increase safe sleep educational awareness to families through materials and resources distributed at District hospitals.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>303</td> </tr> <tr> <td>Denominator:</td> <td>976</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	303	Denominator:	976	Unit Type:	Percentage	Unit Number:	100
Numerator:	303								
Denominator:	976								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Title V Program								
Significance:	<p>Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the AAP has long recommended the back (supine) sleep position. However, in 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Among others, additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.</p>								

ESM 6.1 - Interagency committee meetings to support developmental screenings

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

Measure Status:	Inactive - Completed								
Goal:	Increase the number of interagency meetings held to facilitate communication among providers in support of developmental screening with the ASQ developmental screening tool.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of Interagency committee meetings held within the past year.</td> </tr> <tr> <td>Denominator:</td> <td>Number of Interagency committee meetings scheduled within the past year.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>4</td> </tr> </table>	Numerator:	Number of Interagency committee meetings held within the past year.	Denominator:	Number of Interagency committee meetings scheduled within the past year.	Unit Type:	Count	Unit Number:	4
	Numerator:	Number of Interagency committee meetings held within the past year.							
	Denominator:	Number of Interagency committee meetings scheduled within the past year.							
	Unit Type:	Count							
Unit Number:	4								
Data Sources and Data Issues:	VI Learn the Signs Committee								
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.								

ESM 6.2 - Children receiving a developmental screening using a parent-completed screening tool.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active								
Goal:	To increase the percent of children receiving developmental screening using a parent-completed tool.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>100</td> </tr> <tr> <td>Denominator:</td> <td>200</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	100	Denominator:	200	Unit Type:	Percentage	Unit Number:	100
Numerator:	100								
Denominator:	200								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Title V pediatric and specialty clinics.								
Significance:	<p>Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP.</p> <p>Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006 Jul;118(1):405-20. http://pediatrics.aappublications.org/content/118/1/405</p>								

ESM 8.1.1 - Physical activity counseling during the well-child visit within the MCH population.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active	
Goal:	Partner with the FQHC's to increase the physical activity counseling that occurs during the well child visit visit.	
Definition:	Numerator:	Number of children that received physical activity counseling during their well child visit within the past year.
	Denominator:	Number of children seen by FQHC's for a well child visit during the past year.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Title V Program	
Significance:	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.	

ESM 10.1 - Partnerships with school-based health centers to promote adolescent health services.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Inactive - Completed								
Goal:	Partner with school-based health centers to promote and incentivize adolescent health services.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of schools with school-based health centers that participate in programs to increase the rate of adolescent well-visits.</td> </tr> <tr> <td>Denominator:</td> <td>Number of schools with school-based health centers.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>2</td> </tr> </table>	Numerator:	Number of schools with school-based health centers that participate in programs to increase the rate of adolescent well-visits.	Denominator:	Number of schools with school-based health centers.	Unit Type:	Count	Unit Number:	2
Numerator:	Number of schools with school-based health centers that participate in programs to increase the rate of adolescent well-visits.								
Denominator:	Number of schools with school-based health centers.								
Unit Type:	Count								
Unit Number:	2								
Data Sources and Data Issues:	Title V Program; FQHCs								
Significance:	<p>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs.</p> <p>Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults.</p> <p>The Bright Futures guidelines recommends that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health-related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.</p>								

**ESM 10.2 - Percentage of adolescents, ages 10 through 19, receiving school-based preventive health services.
 NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Measure Status:	Active								
Goal:	Increase the percentage of students receiving school based preventive health care services in the school setting.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>590</td> </tr> <tr> <td>Denominator:</td> <td>11803</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	590	Denominator:	11803	Unit Type:	Percentage	Unit Number:	100
Numerator:	590								
Denominator:	11803								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Title V Program								
Significance:	<p>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs.</p> <p>Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults.</p> <p>The Bright Futures guidelines recommends that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health-related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.</p>								

ESM 12.1 - Use of evidenced-based health care transition tools in public health and FQHC facilities.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active								
Goal:	Increase the use of an evidenced-based health care transition tool for transition readiness assessment in public health and FQHC facilities.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of public health and FQHC facilities using an evidenced-based health care transition toll for transition readiness assessments.</td> </tr> <tr> <td>Denominator:</td> <td>Number of public health and FQHC facilities providing transition services for adolescents with and without special health care needs.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>4</td> </tr> </table>	Numerator:	Number of public health and FQHC facilities using an evidenced-based health care transition toll for transition readiness assessments.	Denominator:	Number of public health and FQHC facilities providing transition services for adolescents with and without special health care needs.	Unit Type:	Count	Unit Number:	4
Numerator:	Number of public health and FQHC facilities using an evidenced-based health care transition toll for transition readiness assessments.								
Denominator:	Number of public health and FQHC facilities providing transition services for adolescents with and without special health care needs.								
Unit Type:	Count								
Unit Number:	4								
Data Sources and Data Issues:	Title V Program; FQHCs								
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.								

ESM 13.2.1 - Percent of Children, ages 1-17, who have had Preventive Dental Health visit in the past year
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active								
Goal:	60								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Children who have had an preventive dental visit in the past year</td> </tr> <tr> <td>Denominator:</td> <td>All children 0-17</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Children who have had an preventive dental visit in the past year	Denominator:	All children 0-17	Unit Type:	Percentage	Unit Number:	100
Numerator:	Children who have had an preventive dental visit in the past year								
Denominator:	All children 0-17								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	FQHC DATA								
Significance:	Dental								

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

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

Measure Status:	Active								
Goal:	Form inter-agency partnerships with FQHCs to improve coordination between dental and other health services.								
Definition:	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;">Numerator:</td> <td>Number of inter-agency partnerships implemented to coordinate dental and other health services.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Denominator:</td> <td>Number of inter-agency partnerships</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Number:</td> <td>2</td> </tr> </table>	Numerator:	Number of inter-agency partnerships implemented to coordinate dental and other health services.	Denominator:	Number of inter-agency partnerships	Unit Type:	Count	Unit Number:	2
Numerator:	Number of inter-agency partnerships implemented to coordinate dental and other health services.								
Denominator:	Number of inter-agency partnerships								
Unit Type:	Count								
Unit Number:	2								
Data Sources and Data Issues:	Title V Program								
Significance:	<p>Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.</p> <p>Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.</p> <p>State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</p>								

**Form 11
Other State Data
State: Virgin Islands**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)