



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

**State Narrative for  
Virgin Islands**

**Application for 2013  
Annual Report for 2011**



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# Table of Contents

I. General Requirements .....	4
A. Letter of Transmittal.....	4
B. Face Sheet .....	4
C. Assurances and Certifications.....	4
D. Table of Contents .....	4
E. Public Input.....	4
II. Needs Assessment.....	6
C. Needs Assessment Summary .....	6
III. State Overview .....	9
A. Overview.....	9
B. Agency Capacity.....	24
C. Organizational Structure.....	34
D. Other MCH Capacity .....	37
E. State Agency Coordination.....	40
F. Health Systems Capacity Indicators .....	46
IV. Priorities, Performance and Program Activities .....	50
A. Background and Overview .....	50
B. State Priorities .....	50
C. National Performance Measures.....	53
Performance Measure 01:.....	53
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated .....	55
Performance Measure 02:.....	56
Performance Measure 03:.....	59
Performance Measure 04:.....	61
Performance Measure 05:.....	63
Performance Measure 06:.....	65
Performance Measure 07:.....	67
Performance Measure 08:.....	69
Performance Measure 09:.....	71
Performance Measure 10:.....	73
Performance Measure 11:.....	75
Performance Measure 12:.....	77
Performance Measure 13:.....	79
Performance Measure 14:.....	81
Performance Measure 15:.....	83
Performance Measure 16:.....	85
Performance Measure 17:.....	88
Performance Measure 18:.....	90
D. State Performance Measures.....	92
State Performance Measure 1: .....	92
State Performance Measure 2: .....	94
State Performance Measure 3: .....	96
State Performance Measure 4: .....	98
State Performance Measure 5: .....	101
State Performance Measure 6: .....	103
State Performance Measure 7: .....	105
E. Health Status Indicators .....	107
F. Other Program Activities.....	113
G. Technical Assistance .....	115
V. Budget Narrative .....	117
Form 3, State MCH Funding Profile .....	117

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds.....	117
Form 5, State Title V Program Budget and Expenditures by Types of Services (II).....	118
A. Expenditures.....	118
B. Budget .....	119
VI. Reporting Forms-General Information .....	122
VII. Performance and Outcome Measure Detail Sheets .....	122
VIII. Glossary .....	122
IX. Technical Note .....	122
X. Appendices and State Supporting documents.....	122
A. Needs Assessment.....	122
B. All Reporting Forms.....	122
C. Organizational Charts and All Other State Supporting Documents .....	122
D. Annual Report Data.....	122

## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section. IA - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

By submission of the Title V Block Grant Application for 2013-2015, The Virgin Islands Department of Health (VI DOH) assures compliance with all requirements established by OBRA '89 (PL 104-193, 1996). Funds allotted to VI will only be used for addressing the identified needs of women, infants, children and adolescents, including those with special health care needs and their families. VI DOH further assures proper management and implementation of the action plan as described in the application. The allotted funds will be fairly distributed across all MCH population groups in accordance to the mandate (30-30-10). These funds will be used only to carry out the purpose of Title V programs and activities, consistent with Section 508.

Under no circumstances will Title V Block Grant funds be used for construction or the purchase of land.

Additionally, we certify that services will be rendered in a smoke-free environment, to provide a drug-free workplace in accordance with 45 CFR Part 76, and to comply with the prohibition of using federal funds to support any activity regarding lobbying or its appearance to.

Signed copies of the Assurances and Certifications required for this application are located at the MCH & CSHCN Program Administrative Office located on St. Thomas, VI.

These forms are available upon request by USPS Express Mail service.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

### **E. Public Input**

Public input into the Block Grant Application is an on-going process. 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. Notices are printed in local newspapers and aired on cable television public service announcements on both islands annually providing information on availability of the block grant application for public review and comment. Public input is also solicited by placing the application in selected community partner agencies, with a special focus on those who provide advocacy and outreach services to children with special health care needs and their families. Response forms accompany each copy with options to accept the application as written or accept with changes and / or additions.

Public participation in these reviews has not been as great as anticipated. The program makes

every effort to encourage individuals who use program services to voice their concerns or ideas regarding the quality and effectiveness of the services received. These families rarely would attend a formal meeting or focus group concerning the Title V Program.

MCH met with its partners on July 12, 2012 to review and discuss the Block Grant. Representatives from 5 different agencies (MCH Nursing, Early Childhood Advisory Committee (ECAC), VI Community Foundation, Virgin Islands Perinatal Incorporation (VIPI), Government House) attended and provided good feedback and discussion.

In general, the partners commented that the session was very informative and provided greater insight as to the mission, vision, goals and objectives of MCH, and hence provide a clearer understanding of how service- coordination can be improved between MCH and the various organizations/agencies. There were agencies /organizations who were able to provide additional information regarding their activities and other activities that were not documented in the Block Grant such as, the Dept of Human Services' obesity prevention initiatives; the adoption of the Strengthening Families Approach program by the Early Childhood Advisory Committee (ECAC); the mental health services that are being provided by Early Head Start and Head Start Program; etc.- all programs/services that address several of the needs of the territory's women, children and adolescents. Although the representatives from the VI Here To Understand and Give Support (HUGS VI) and the Inter-Island Parent Coalition for Change (IIPCC) were unable to attend the meeting, these programs have been instrumental in providing additional resources and support for our vulnerable populations, such that parents have commented that through the services these programs provided, they (parents) were able to get additional help they needed during very difficult times. The collaboration that exists between MCH and these two programs is invaluable and continues to help MCH improve the services being provided; therefore, the continued input of HUGS VI and IIPCC is highly regarded and beneficial for the MCH program to move forward towards achieving its goals and objectives.

In this day of increasing technological advances, the MCH program intends to develop its website under the VI DOH website and to utilize the web site as a portal for the public to gain access to information regarding the MCH services/programs as well as to have continuous access to the MCH Block Grant. The website will also enable the public to make comments regarding the services provided and will be linked to various educational sites and programs that provide materials relative to parenting, pregnancy issues, child development and child health care. The MCH program has been advocating and will continue to advocate the use of "TEXT FOR BABIES" as a means for mothers to gain access to pertinent information related to their pregnancy.

## **II. Needs Assessment**

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

#### II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

#### C. Needs Assessment Summary

##### Summary of 2010-2015 USVI MCH Block Grant Needs Assessment

Perhaps the most important implications of this needs assessment relates back to two strategies: 1) Increasing services to the MCH population in all areas of primary and preventive care, and 2) Collaborating with other agencies providing services to the MCH population to increase the access to the health care system. These strategies must be done in conjunction with health care providers as critical partners. Increasing availability and access to primary and specialty care, although important, will not improve health outcomes unless the services provided are also developmentally appropriate and are engaging in a way that is likely to lead to behavior change. Providers alone cannot accomplish this, but by partnering with other key stakeholders in improving adolescent health, they can leverage their influence in positive ways. The Institute of Medicine has focused on the need to prepare a MCH workforce better prepared to address the health needs of adolescents. Although resources are limited, the Rochester LEAH program that developed and analyzed the Adolescent Health survey is interested in addressing this very palpable need in the USVI, including developing an educational program for providers, possibly using advanced telemedicine technology available at the University of Rochester.

During this cycle of the 5-year Needs Assessment process, almost 300 teenagers were surveyed using reliable and valid tools designed to assess the health and health needs for a representative sampling of adolescents living in the USVI. Gathering information on this particular population was stressed as it is a segment that has historically been underrepresented in the assessment process. The key findings represent both challenges and opportunities. The health challenges 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. For example, children and adolescents with complicated diabetes are sometimes flown to Puerto Rico to see a pediatric endocrinologist, since none is available in the USVI. 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.

It is clear that for many youth health risk behaviors begin before their teenage years. Thus, preventive efforts need to begin earlier, in childhood or before. Also, the issue of disparities became evident insofar as youth at a private school had many more opportunities to engage in physical education in school than did some youth in public schools. This may be related to socio-economic status, which is known to confer some degree of protection in itself, but community-based, youth-development approaches that reach a broad array of youth may be more beneficial than school-based interventions. In addition, youth reported different levels of rules and rule

enforcement at school and at home. Having consistent, pro-social messages across all of their environments about rules tends to be associated with youth having more protective factors and fewer risk behaviors. The MCH community can have an important role in this regard, because a majority of respondents found that having talked about topics with a health provider was helpful or very helpful. This is likely to apply to parents and parenting, as well. Therefore, continued participation on the part of MCH in the Dept. of Education's Parent University's initiative ( a program to train/educate parents with respect to various parenting topics/issues is a good way to enhance parenting skills to deal with many of the social adolescent issues. Also, the initiation of the Parent Cafes (open parent forum to discuss many of the parental issues/concerns) as part of the Best Beginnings Program (annual collaborative territorial training for Early Education Teachers, parents, health care providers) is another way that the territory can collaboratively continue to address parental concerns and problems that will further empower parents to deal with many of the issues/concerns of the adolescent population.

Primary and specialty care providers are influential providing consistent messages to youth and their parents, with specific, concrete suggestions to modify behavior using motivational interviewing techniques. Again, consistency in responding to adolescent behaviors at home and in schools is likely to be helpful. This influence must be provided based on a sound understanding of the needs of adolescents and the issues that occur at different developmental stages. In view of this, workforce development must occur and as such,

the MCH program sponsored in collaboration with the State Adolescent Health Resource Center/Konopka Institute of Minnesota, a 3 day training/workshop for the VI partners/stakeholders from various organizations/agencies (Dept. of Education, Dept of Human Services, various community-based organizations, FQHC's) to discuss adolescent health issues and to begin developing a state plan that would effectively address adolescent health care issues. This training was conducted in March 2011 by Kristin Teipel, Director of State Adolescent Health Resource Center/Konopka Institute for Best Practices in Adolescent Health University of Minnesota and some of her staff. This was a wonderful opportunity for various stakeholders and healthcare providers to come together to relay concerns and to provide suggestions and valuable information about how to address many of the adolescent issues stated in the Needs Assessment. This training/workshop was to be the first of several others in order to accomplish the task of developing and implementing a State Plan for Adolescent Health Care. Engaging major stakeholders in the planning phase is seen as essential for the success of developing and implementing a State Adolescent Health Care Plan considering the economic climate that has significantly affected financial and personnel resources. It is anticipated that maintaining these partnerships will be crucial to creating the capacity that is needed to effectively carry out a State Plan. In 2013, there will be another training to review the State Plan -- identify strengths and weaknesses to then move towards the creation of an Action Plan.

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. Then, there is public, proactive campaign to reduce the burden of illness due to obesity in children and adults on all islands and activities linked to this objective are the department's broad-based community education and outreach campaign; MCH providers counsel of clients on health behaviors linked to obesity; Public Health Week and year round activities; and the CBOs programs for children, youth and families to further reduce obesity among this population.

In reviewing the Title V performance indicators, the Virgin Islands has several areas that need improvement in the provision of prenatal care services. The 2010 Prenatal Care Needs Assessment Survey provided the baseline data considered in the determination of priority areas of this prenatal health care plan. Targets to be attained during the 5-year period were determined

to be most appropriate and feasible. The VI Maternal Child Health Program will work to address the identified priority needs in the next 5 years. In the face of these challenges, it will strive to develop and implement appropriate interventions to address these concerns.

### **III. State Overview**

#### **A. Overview**

##### A. Overview

#### III-A. STATE OVERVIEW

##### A. Overview

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 U.S. Virgin Islands is an unincorporated territory of the United States, with a local government structure defined by the federal Revised Organic Act of 1954, as amended. Internal political affairs are under the jurisdiction of an elected governor and a 15-member unicameral legislature. In addition to the U.S. District Court, the U.S. Virgin Islands has its own system of local courts, including a Superior Court and Supreme Court.

USVI residents are citizens of the United States. They elect the Governor, a fifteen member Legislature, and a non-voting Delegate to the U.S. House of Representatives. This official can vote in committee, but does not have a vote on legislation in the full House of Representatives. USVI residents contribute to Social Security, serve in the U.S. military, and can be called for military service. They do not pay federal income taxes and or vote in U.S. presidential elections. Residents are eligible to participate in federal government programs, but levels of assistance are usually lower than those provided for people living in the 50 states and the District of Columbia.

**Geography:** The Territory of the U.S. Virgin Islands (USVI) is a collection of four major islands-St. Croix, St. Thomas, St. John, Water Island, and 70 smaller islets and cays. The location of the Territory is 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 economic development. It has two main towns-Christiansted, the larger of the two on the east, and Frederiksted, on the west.

Forty miles due north, St. Thomas is approximately 32 square miles and has 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.

A few miles east of St. Thomas lies St. John, offering a similar land and seascape. More than half of the island is designated as a National Park, which has served to preserved much of this island's natural beauty. The main town of 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.

**Health Care Delivery Environment:** 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.

Population: According to the 2000 USVI Census Bureau, the population of the Virgin Islands was 108,612 persons: 53,234 on St. Croix, and 55,378 on St. Thomas/St. John. St. Thomas has the highest population density of 1599 persons per square mile, more than twice that of St. Croix with 642 persons per square mile. St. John has the lowest population density of 214 persons per square mile.

Subsequent annual Community and Household Surveys performed by the University of the Virgin Islands Eastern Caribbean Center reflects that even with overall population increases each year there were small but steady population downward shifts in the birth -- 19 population during the period 2003 -- 2007.

According to the 2007 VI Community Survey (VICS), the USVI population consisted of 114,744 persons; 56,240 on St. Croix and 58,504 on St. Thomas/St. John (Table 1). This corresponded to a 5.6% increase from the 2000 U.S. Census population of 108,612. The 2007 VICS estimated that males represented 48% (55,269) of the population with females at 52% (59, 475) (Table 2). 2007 USVI Community Survey (VICS), Eastern Caribbean Center, University of the Virgin Islands.

/2012/ The VICS performed in 2008 shows an increase in the VI population to 115,852 persons; 56,783 on St. Croix and 59,069 on St. Thomas/St. John. This reflects a 1% increase from the 2007 survey. Estimates show that males represented 47% (54,110) of the population with females at 53% (61,742). //2012//

***/2013/ The 2009 CVI Community Survey captured an 8% decrease in the overall population in the U.S. Virgin Islands. Territorially, the population stood at 107,249, with 52,612 people living on St. Croix, 50,583 on St. Thomas, and 4,148 on St. John. //2013//***

Table 1 (VI Population by island)

	USVI	St. Thomas	St. Croix	St. John
2000	108,612	51,181	53,234	4,197
2005	111,740	52,528	54,635	4,307
2007	114,744	54,070	56,240	4,434
2008	115,852	56,783	54,592	4,477
2009	107,249	50,583	52,612	4,148

Chart 1 (VI Population by island 2000-2008 - see attachment)

Table 2 (VI Population distribution)

	2000	2005	2007	2008	2009
Male	51,684	52,052	55,269	54,110	50,133
Female	56,748	59,418	59,475	61,742	57,116

Chart 2 (VI Population by distribution 2000-2008 - see attachment)

Population less than 19 years: In 2007, children and youth 0 -- 19 years represented 26.6% (30,596) of the population, this represents a 4.4% decrease from the total population in that age group (34,556 or 31%) from 2005. This downward trend is further underscored by the data for each of the individual age groups in this population. In 2007 Children under age 5 represented 6% (5,809) of the population a decrease from 7.1% (7,937) in 2005. That same year, children ages 5-9 show a decrease of 5.4% (from 7,866 in 2005 to 7,440 in 2007) and a decrease in ages 10-14 of 7.9% going from 10,002 in 2005 to 9,209 in 2007. Lastly, adolescents (teens) ages 15-19 also had a decrease of 7% going from 8,751 in 2005 to 8,138 in 2007 (Table 3).

/2012/ The 2008 VICS reports a small decrease from 2007 in the population 0-19 years which has experienced a downward trend since the 2000 Census. 2010 Census data is not available at the time of the report. //2012//

**/2013/ For 2009, the VICS again reported an overall decrease in the number children and youth 0-19 years among the VI's population. Children under the age of five increased by 22.4% from 2008 to 2009. /2013//**

**Table 3 (Children and youth 0 -19 years).**

Age	2009	2008	2007	2005	2000 Census
Under 5 years	7,071	5,774	5,809	7,937	8,553
5-9 years		6,557	7,297	7,440	7,866
10-14 years	6,788	8,557	9,209	10,002	9,676
15-19 years	7,936	8,451	8,138	8,751	6,688
<b>Total</b>	<b>28,352</b>		<b>30,079</b>	<b>30,596</b>	<b>34556</b>

**Chart 3 (Children and Youth 0 -- 19 years 2000-2009 - see attachment)**

**Table 3-A. Single years 0 -- 1 year (2008)**

single years	Total
<b>Total</b>	<b>115,852</b>
<b>0</b>	<b>807</b>
<b>1</b>	<b>1,310</b>

**Population by Age and Percentage: The VI population increased 12.7% overall during the period 2000-2007 (101,809 to 114,744), with a significant decrease evident in the 0 -- 5 and 5-19 age groups (36% and 16.9% respectively). Concurrently, the 20- 59 and 60+ age groups showed increases of 12.8% and 151% respectively (Table 4).**

/2012/ Comparison of 2000 (Census) and 2008 (VICS) shows varying changes in populations ages 0-19 which both decreased, while an increase is demonstrated in the populations over age 60 yrs.

**/2013/ Sustained increases in population since the 2000 Census are noted in the 20-59 and over 60 age groups as based on the 2009 VICS. //2013//**

Table 4 (Population by Age and Percentage)

Category	Census		2007		2008		2009		% Increase/Decrease
	2000	%	2007	%	2008	%	2009	%	
Overall %Change									
< Age 5	8,553	7.9 %	5,809	5.1%	5,774	5%	7,071	6.5%	-1,482
									-17%

Ages 5-19	26,540	24.5 %	24,787	21.6%	24,305	21%	21,281	19.8%	-5,259
									- 19%
Ages 20-59	53,083	49%	59,896	52%	60,497	52.2%	56,570	52.7%	+3,487
									+6.5 %
Over Age 60	9,659	9%	24,252	21.1%	25,276		21.8%	22,421	20.8%
	+12,762	+32%							
Total	108,612	100%	114,744	100%	115,852	100%	107,343	100%	1,269
									- 1.1%

Chart 4 (VI Population by Age 2000-2009)

Population by Race / Ethnic Composition: 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 may be other Spanish-speaking islands, such as Puerto Rico or the Dominican Republic. The 2000 Census estimated the racial composition of the V.I. population as Black/African American 76.2%, Whites 13.1 %, Other races 7.2% and Two or more races 3.5% (Table 5). The 2007 USVI Community Survey showed a change in these demographics with 88,336 Blacks (76.9%), 10,183 Whites (8.87%) and 16,225 (14.2%) Other races (Table 5).

/2012/ The 2008 VI Community Survey shows a less than 1% change in the Black/African American (89,341) population from 2007(88,336). There was also a slight increase (0.5%) in Whites (10,892); and a slight decrease (0.7%) in Other races (15,619). Overall, all population demographics remained relatively stable with an approximate 1% increase from 2007 to 2008. //2012//

**/2013/ For 2009, the VICS shows further slight decreases in the Black/African American (0.3%) and White (0.5%) populations, with Other Races increasing by 0.8%. //2013//**

Table 5 (Population by Race)

Year	Census 2000		2007		2008		2009	
	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%
White	14,218	10.6%	10,183	8.87%	10,892	9.4%	9,616	8.9%
Other Races	11,644	12.1%	16,225	14.2%	15,619	13.5%	15,321	14.3%

Chart 5 (Race/Ethnic Composition 2000-2009)

Population by Hispanic or Latino Origin: The 2000 Census estimated 93,416 persons of non-Hispanic origin and 15,196 persons of Hispanic origin (Table 6). According to the 2007 Virgin Islands Community Survey (VICS), by 2007 the number of persons of Hispanic origin increased to 20,850 (18%) of the population (Table 6). The majority of Hispanic residents continue to reside on St. Croix with an estimated population of 13,881 (12%).

/2012/ The demographics for this population show a less than 2% increase overall. A slight increase in the number of Puerto Rican residents (2.1%) is noted, along with a slight decrease in the number of residents from the Dominican Republic (0.6%). //2012//

**/2013/ Demographics for this population changed slightly with a 2% decrease among Puerto Rican residents while Other Latino/Hispanics increased by 2%. //2013//**



Table 8. (Per Capita and Median Income Comparison)

	2005	2006	2007	2008	2009
US Per capita	20.4	36,714	38,611	40,166	39,138
USVI Per capita	15,459	16,286	16,562	17,545	17,860
US Family median income	54,081	58,407	58,480	63,211	60,088
USVI Family median income	38,914	42,673	43,949	43,691	

Chart 7. (Per Capita and Median Income)

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

Poverty Status: Poverty rates in the Virgin Islands are extraordinarily high compared to rates in the US. In 2007, the US Census Bureau defined the poverty line as an individual income of \$10,590 or less per year, or an income of \$21,027 or less per year for a family of four. In the VI one in five families earned less than \$15,000 per year (21%) in 2007. This equates to approximately \$10 a day per person for a family of four and is 22% below the federal poverty threshold. In 2007, one out of every four (24%) families in the Virgin Islands lived in poverty. More than one third (34.1%) of VI children are growing up in households with incomes below the poverty threshold, almost twice the national child poverty rate of 18%. Despite a decreasing child population, the trend continues to rise as one out of every three children in the Virgin Islands lives in poverty. (Source: VI Kids Count Data Book 2007 -- Community Foundation of the V.I.) /2012/ In 2008 the VI child poverty rate fell to 28% far below the average yearly rate of 35%. More than one of every four VI children is living in poverty. 72% of poverty-level families with children are headed by single mothers. //2012// Source: USVI Kids Count Data Book 2010. **/2013/ The number of children living in poverty increased to 29.9% in 2009, as compared to 20% nationally; 21% of VI families continue to live in poverty //2013//** Source: USVI Kids Count Data Book 2011.

Table 9. (Children living in poverty)

	2001	2003	2005	2007	2008	2009
USVI child poverty rate	36.5%	32.3%	35.8%	34.1%	28.1%	29.9%
US child poverty rate	16.3%	18%	19%	18%	18%	20%

Chart 8 (Children Living in Poverty)

Income comparison of Families below poverty level: Families below poverty level based on income earned in 2007 was 6,838. Children under 18 years in families below the poverty level represented 4,133 of the population in 2007. Families with income below the poverty level with no husband present totaled 3,724 (54%). One third of the total VI population (32,650 individuals) lived an average of 28.5% below the poverty level in 2007.

(Source: 2007 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands).

***/2013/ The percentage of VI families with children living below the poverty level increased to 24.9% in 2009 as compared to 24.8% of families in 2008. Of the VI families with children living in poverty, 74.7% were headed by single mothers, an increase from 72.3% in 2008. //2013//***

Table 10. (Income Comparison of Families below poverty level)

Population	Families below poverty level		2007		2008		2009	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Families	6,364	22.4%	6,838	23.7%	6,566	22.5%	5,982	21.3
Families w/related children <18 years	4,292	28.4%	4,133	28.8%	3,544	24.8%	3,431	24.9
Families with no husband present	4,004	37.7%	3,724	36.4%	3,514	38.6%	3,240	37.4
Individuals	29,794	26.8%	32,650	37.3%	31,971		27,673	25.8

Source: 2004 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands; 2000 USVI Population Census, US Census Bureau; 2005 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands; 2007 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands.

*/2012/ Source: 2008 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands; USVI Kids Count Data Book 2010. //2012//*

***/2013/ Source: 2009 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands; USVI Kids Count Data Book 2011. //2013//***

Children Living with One or More Parents: In 2007, one third (33%) of the VI children lived with two married parents compared to the national average of 68%. More than half (55.8% or 15,578) of VI children live in single-parent families. Of that number, 46.4% (6,641) lived in families headed by single-mothers compared to the national average of 18.7%. Of the VI families with children headed by single mothers, 70.1% live in poverty. Children from birth to five years old are developmentally most vulnerable to poverty's impacts -- yet this age group has the highest rate of child poverty.

Source: VI Kids Count Data Book 2009- Community Foundation of the V.I.

***/2013/ In 2009, the number of VI children living with a single parent increased to 58.8%, compared to 32% nationally. 41.6% of VI children lived in families headed by single mothers, 17.2% lived in families headed by single fathers, and 8% lived with neither parent. //2013//*** Source: USVI Kids Count Data Book 2011

Educational Attainment: In 2007, of the 78,741 persons 25 years and older over 64% were high school graduates or higher and 15.8% had received a bachelor degree or higher, more than half (53.7%) were female. Individuals with less than a ninth grade education represented 18.4%, and persons who received a ninth to twelve grade education but no diploma represented 17.5%. Public and non-public school enrollment as of 2007 was 29,832, an increase of 4,212 or 16.4% in the last 10 years. The rate of high school completion in 2007 for VI youth age 18-24 was 63.1% (an increase from 64.1% the previous year). Only 4.6% of youth in this age group went on to earn a college degree by age 24.

Source: 2007 USVI Household Income & Expenditure Survey, Eastern Caribbean Center,

University of the Virgin Islands.

**/2013/ In 2009, 66.8% of persons 25 and older were at least a high school graduates and 16.7% had received a bachelor degree or higher. //2013//** Source: 2009 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands.

Table 11: Comparison USVI Educational Attainment- 2000, 2005, 2007, 2008, 2009

	2000	2005	2007	2008	2009						
Educational Attainment	Number	Percent	Number								
25 years and older	80,079	100	65,603	100	73,799	100	71,048	100	78,471		
Less than 9th grade	13,887	17.3	11,387	15.4	14,813	20.8	14,442		18.4		
9th to 12th grade, no diploma	13,743	17.7	13,079	20.9	20,721	29.1	13,794		17.6	14,893	18.6
High School Graduate, includes equivalency	17,044	26.0	14,048	19.8	21,004	26.8	24,030	30	22,599	30.6	
Some college, no degree	9,425	14.4	9,386	13.4	11,936	15.2	10,994	13.8	10,282	14	
Associate degree	2,269	3.5	3,444	4.8	4,880	6.2	4,133	5.1	3,392	4.6	
Bachelor degree	6,841	10.4	5,547	7.8	8,716	11.1	8,125	10.1	9,059	12.3	
Graduate/ Professional degree	4,148	6.3	3,089	4.3	3,698	4.7	4,018	5.0	4,001	5.4	

Source: 2004, 2005 & 2007 & 2008 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands.

**/2013/ 2009 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands//2013//**

Public School Drop Outs: In 2008-09, the VI public secondary school initial enrollment was 5, 182 students. The dropout rate reported by the VI Department of Education for that school year was 7.47% (387 students), a 3.9% decrease (403 students) from the 2007-2008 school year.

Historically, data shows ninth grade as a year of high risk for dropping out in the VI public school system. During the 2008- 2009 school year, ninth graders continue to have the highest number, with 196 dropouts (or 10.6% of enrolled ninth grade students). Source: Department of Education, Office of planning, Research and Evaluation 2008- 2009.

/2012/ Public secondary school enrollment was 5,065 for the 2009-2010 school year. The dropout rate is reported at 6.2% overall (316 students) a 1.27% decrease from the 2008-2009

school year. Data shows a significant decrease (3.3%) in the dropout rate for ninth-graders which is 7.3% or 123 enrolled students for the 2009-2010 school year. //2012// Source: Department of Education, Office of Planning, Research and Evaluation 2009-2010.

**//2013/ For the 2010-2011 school year, public secondary school enrollment was 5,170, of that number the dropout rate was 4.95%. 5% of enrolled ninth graders dropped out in the 2010-2011 school year, continuing a downward trend among this age group. //2013//**  
 Source: Department of Education, Office of Planning, Research and Evaluation 2010-2011.

Chart 9A: Public Secondary School Drop Out Rate By Grade

Chart 9B: 2009-2010 Public School Secondary Drop Out Rate By Gender

Chart 9C: USVI Public Secondary School Drop Out Rates By Year

**\*\*Note:** percentages reported are based on constituent school populations, not the territorial population. Numbers and rates reported are for the VI public school students, and do not include students in private schools. Youth who do not finish high school frequently lack the minimum skills and credentials for today's changing job market. These young people will have a more difficult time securing employment, advancing in a job, and receiving wages able to support a family adequately. When unemployed, these youth are at greater risk of engaging in antisocial and crime-related activity. Source: 2007 VI Kids Count Data Book. Community Foundation of the VI.

Employment Attainment: Employment attainment for the 16-19 years age group in 2007 was 26% (1, 695) an increase from 23.6 % (1,538) in 2006. In the 20 -- 24 years age group, 62.5% (3,546) were employed in 2007, a slight decrease from 67.8% in 2006. Source: 2004, 2005 & 2007 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands

**//2013/ According to the 2009 VICS, 2.7% of youth age 16-19 reported working full-time in 2009 compared to 5% in 2008. Of those age 18-24, 62.5% were employed, a slight decrease from 63% in 2008. //2013//** Source: 2009 USVI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands & 2011 VI Kids Count Data Book. Community Foundation of the VI.

Language: English is the only spoken language at home for 72.6% of the population 5 years and over. A language other than English (Spanish, French, Indo-European language and Asian/Pacific Island languages) is spoken by 27.4% of the population 5 years and over (Table 11).

Table 12: USVI Spoken Language

	2000		2005		2007		2008		2009	
Population	Number	Percent								
5 years and over	100,059	100.0	100,272	100.0	103,533	100.0	108,935	100.0	110,078	100.0
English	74,740	74.7	82,518	79.7	79,104	72.6	81,395	74	75,371	75
Language other than English	25,319	25.3	21,015	20.3	29,832	27.4	28,683	26	24,901	25

Source: 2005 and 2007 Virgin Islands Community Survey, Eastern Caribbean Center, University

of the Virgin Islands; 2000 USVI Population Census, US Census Bureau.  
 /2012/ 2008 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands. //2012//  
**/2013/ 2009 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands. //2013//.**

Disability Status of the Non-Institutionalized Population (Special Needs): Table 12 shows disability of persons (five years and over) such as: severe hearing, vision impairment; substantial limitation in their ability to perform basic physical activities; difficulty learning, remembering or concentrating, difficulty in performing activities of daily living, persons sixteen years and over are considered to have a disability if they have difficulty going outside the home alone to shop or visit a doctor's office.

Table 13: Comparison- Disability Status by Age Group

	2000		2005		2007		2009	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Population	29,697	100.0	26,619	100.0	24,780	100.0	21,281	100
5 -20 years	29,697	100.0	26,619	100.0	24,780	100.0	21,281	100
With a disability	1,402	4.7	1,200	4.5	783	3.16	758	4.38
21-64 years	60,632	100	62,971	100	53,791	100	64,985	100
With a disability	11,371	18.8	8,505	13.5	6,078	11.3	5,511	8.4
65 and Over	8,947	100	13,944	100	15,257	100	14,006	100
With a disability	3,424	38.3	6,133	43.9	6,086	39.9	7,451	53.1

Table 12: 2000 USVI Census Disability status of the non-institutionalized population; 2005 and 2007 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands  
**/2013/ Source: 2009 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands. //2013//**

Local Area Economic Overview: St. Croix's economy is primarily based on manufacturing. Major industries 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 2009 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. The territory's unemployment rate reached 8.5% in September 2009, 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. Source: USVI Bureau of Economic Research October 2009

/2012/ Recent data suggest that key sectors continue to improve, but slowly. In particular, the tourism, construction, and other services continue to gain traction, while sectors such leisure and hospitality, transportation, warehouse and information were beginning to show signs of resurgence.//2012//

Source: USVI Bureau of Economic Research October 2010

/2012/ The unemployment rate moved to 9.1% in the month of April 2011. The labor market

experienced the highest rates since the economic slowdown occurred back in 2008. This uptick is primarily due to local market job losses in the private sector. St. Croix's rate climbed to 11% for the month based on high initial claims count, in addition to 2nd week continued unemployment claims that have persons on extended unemployment compensation rolls. St. Thomas/St. John also saw increased claim factor, based on major hospitality sector employer reducing the workforce during the off season for tourism associated activities. On the over the year analysis, the local economy continues to limp along with small to minimal growth in other sectors. The effects of the continued soft recovery on the global market, and local conditions related to government revenue, and slowdown in public projects have impacted the expansion of labor market activity.//2012//

Source: V.I. Department of Labor: Unemployment Rate 2011

**/2013/ There were 47,114 persons employed in civilian jobs in the first quarter of fiscal year 2011 compared to 48,101 in fiscal year 2010. There were 20,259 employed on St. Croix and 26,855 on St. Thomas and St. John. Each district experienced a 2.1 percent decline in civilian jobs in the first quarter. //2013//** Source: VI Bureau of Economic Research 2011 Economic Review

Government /public sector employment which comprised 27% of total wage and salary jobs increased 0.6% in 2009. Local Government jobs averaged 12, 019 up 0.4 percent over 11, 969 in fiscal year 2008. Federal employment grew 2.5% to an average of 975 jobs for the year. Local government jobs are expected to continue to decline in fiscal year 2005 as part of the government's cost cutting initiatives through attrition, retirement and elimination of vacant positions.

**/2013/ Public sector jobs increased by 1.0 percent, as Federal government jobs declined 2.1 percent to an average 962 from 983 in fiscal year 2010. Local government jobs averaged 12,062, up slightly by 1.2 percent from fiscal year 2010 first quarter average of 11,918. //2013//** Source: VI Bureau of Economic Research 2011 Economic Review

Private sector jobs which account for 73% of total wage and salary jobs decline 3.4% to 32,279 in fiscal year 2009 down from 33,421 in 2008. Second to government, the service industry employs the most V.I. workers. An upturn in the tourism and hospitality industry, specifically in hotel accommodations, has improved this sector's performance. The sector is expected to grow during the next fiscal year as demand grows in travel and tourist related industries. This sector includes hotels, business, legal, educational, auto and miscellaneous repair services.

**/2013/ The number of private sector jobs increased 2.1 in the first quarter, continuing the upward trend from the fourth quarter last fiscal year. Private sector jobs averaged 30,898 compared to 30,271 in fiscal year 2010. //2013//** Source: VI Bureau of Economic Research 2011 Economic Review

The trade, transportation and utilities sectors experienced the effects of a drop in consumer spending, travel and other transportation related services. Jobs, in this sector remained stable in transportation, warehouse and utility with an average of 1,624 jobs. But wholesale and retail sectors showed a decline with a loss of 0.6% from 6,293 from 6,331 in fiscal year 2008 in retail jobs and 2.6% decrease in wholesale jobs.

**/2013/ The number of jobs in the trade transportation and utilities sectors declined 1.8 percent in the first quarter, with an average of 8,194 jobs compared to 8,345 in the first quarter last fiscal year. Retail trade jobs, which account for 74 percent of all jobs in this sector and 90 percent of jobs in trade, declined 1.8 percent in the first quarter, with jobs averaging 6,033 compared to 6,145 in the first quarter of fiscal year 2010. Wholesale trade jobs declined 5.2 percent to an average of 651 from 687 last year. Jobs in transportation, warehouse and utility were reduced by 1.4 percent to 1,492 from last year's average of 1,514 jobs. //2013//** Source: VI Bureau of Economic Research 2011 Economic Review

The construction sector had the most significant loss of jobs seen in fiscal year 2009 with a significant 26% year-on-year decline. The number of construction jobs averaged 2,553 compared to 3,426 seen in fiscal year 2008. A significant decrease in private non-residential and private

residential construction primarily accounted for the drop in construction.

***/2013/ The construction sector is investment-led and, therefore, it is one of the sectors hit hardest by the fall-out in the housing and real estate market. But the pace of construction is slowly improving, though nowhere near the level of activity prior to 2008. //2013//*** Source: VI Bureau of Economic Research 2011 Economic Review

Finance, Insurance, and Real Estate sector which accounts for 4% of the territory's employment, experienced a drop in home sales activity, real estate development and average home prices in 2009. In fiscal year 2008 the average price for homes in the Territory fell 12%. The number of homes sold fell 26 percent to 334 from 454 in fiscal year 2007, the lowest in the past ten years. ***/2013/ The number of jobs in finance, insurance, and real estate declined 1.8 percent in the first quarter 2011 to an average 2,352 from 2,396 in fiscal year 2010. //2013//*** Source: VI Bureau of Economic Research 2011 Economic Review

Manufacturing which accounts for 5% of nonagricultural jobs, averaged 2,296 for fiscal year 2009, a 0.7% decrease from 2,311 for the same period in fiscal year 2008.

***/2013/ While added value produced in the manufacturing sector as a proportion of gross territorial product (GTP) is about 21 percent, this sector has a large impact on other sectors and on St. Croix's economy particularly. Manufacturing jobs barely improved in the first quarter. The number of jobs averaged 2,116, up a marginal 0.4 percent over the corresponding period last year. In 2010, the Hovensa Oil refinery lowered its production capacity by almost 30 percent, from 525,000 barrels a day to 350,000 barrels per day to improve its financial performance and resolve ongoing emissions and operating issues. Manufacturing sector jobs are expected to decline this year, primarily the result of reduction in Hovensa's workforce as part of the refinery's cost-cutting measures and efforts to improve its financial position. //2013//*** Source: VI Bureau of Economic Research 2011 Economic Review

***/2013/ The outlook bodes well for the rum industry. The government signed two 30-year agreements, one with Cruzan VIRIL to expand the rum distillery, thereby increasing rum production by 50 percent. A similar agreement was signed with Britain's Diageo PLC, the world's leading spirits, wine and beer company for the construction and operation of a high-capacity distillery on St. Croix. The distillery began production in 2011, and by 2012 will supply the rum used to make all Captain Morgan branded products for the United States. Revenues from the sale of Cruzan and Diageo's rum products are projected to generate over \$100 million annual from each distillery. //2013//*** Source: VI Bureau of Economic Research 2011 Economic Review

Transportation, communications and public utilities remained stable for 2003 and account for 6% of all employment. Jobs in the sector were decreased by 1.2% for the first six months of fiscal year 2004 when compared to the same period in 2003 and employment is likely to remain stable for the remainder of 2004 and is expected to improve in 2005. Source: USVI Bureau of Economic Research October 2009

General labor force trends: Initial effects of the recession and contraction of Virgin Islands labor market began around December 2008, later than the national labor market. In 2009, there were 48,559 persons employed in civilian jobs with 20,881 on St. Croix and 27,678 in the St. Thomas/St. John district. This amounted to a 2.1% decrease from a total of 49,621 in fiscal year 2008.

***/2012/*** Civilian employment fell 3.8 percent year-on-year, for a net loss of about 1,874 jobs. There were 47,368 persons employed in civilian jobs in fiscal year 2010 compared to 49,242 in fiscal year 2009. There were 20,368 on St. Croix and 27,000 on St. Thomas and St. John. Comparatively, in fiscal year 2009 St. Croix had 21,174 employed persons while St. Thomas and St. Croix had 28,068 employed persons. ***/2012//***

***/2013/ There were 47,114 persons employed in civilian jobs in the first quarter of fiscal year 2011 compared to 48,101 in fiscal year 2010. Each district experienced a 2.1 percent***

**decline in civilian jobs in the first quarter, with 20,259 employed on St. Croix and 26,855 on St. Thomas and St. John. //2013//** Source: VI Bureau of Economic Research 2011 Economic Review

Economic Outlook: The broad economic improvements visible since the second quarter continued, but the gradual pace of recovery eased in the fourth quarter of fiscal year 2010. Labor market data confirm the general slowing trend. The Territory's unemployment rate increased since June from 8.1 percent to 8.3 percent in September. Underscoring the lackluster job market, jobless claims have also been trending upward since June, to an average of 400 claims in the fourth quarter. Comparatively, unemployment claims averaged 331 in the first quarter, 301 in the second quarter and 327 in the third quarter. The local economy is expected to make moderate progress in line with the national outlook for growth, although the rate of rebound will continue to be sluggish in 2011 and 2012. The strength of the recovery, however, is contingent on business investment which will be the major driver of economic growth and job creation over the next few years.//2012// Source: USVI Bureau of Economic Research - October 2010

**/2013/ Even though the economy is recovering, it is not robust and masks a number of continuing weaknesses. The unemployment rate, for example, remained high linked to the slow growth of demand from consumers and meager business investment. The housing and real estate market continues to be depressed as observed from lower construction spending manifested through the drop in value of residential and commercial building permits. Furthermore, operational issues and financial losses in Hovensa are profoundly affecting jobs in the manufacturing and constructions sectors in particular and the performance of the economy in general. With the closing of Hovensa this year, we anticipate increasing numbers of unemployed individuals as approximately 2,000 individuals will be laid off. This will have a tremendous negative impact on the economy and increasing efforts to accomodate the number of underinsured and un-insured will have to be made. Discussions regarding regaining designation as a Health Professions Shortage Area (HPSA) and employing individuals from the National Health Service Corp have already begun.**

**To compound matters, the government proposed a number of austerity measures to offset the significant drop in government revenues brought about by the economic downturn, and to address the severity of its budget imbalance. These measures include lay-offs, various tax increases, a freeze on hiring, a two-year freeze on salaries and compensation, deferment of negotiated wage increases, and non-compensation for three legal holidays. Government cutbacks, accordingly, will likely trickle throughout the economy, thereby offsetting job gains to an extent.**

**Despite promising signs that have recently emerged, a weak job market, the government's projected \$75.1 million budget deficit in fiscal year 2011 and \$131.5 in fiscal year 2012, operational and financial**

**problems in the refined-petroleum industry and rising energy costs will present tough challenges over the next two years. //2013//** Source: VI Bureau of Economic Research 2011 Economic Review

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. Hurricane season is from June to October. 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. In the event of land fall, the economic impact can be very devastating.



*An attachment is included in this section. IIIA - Overview*

## **B. Agency Capacity**

### III - B. STATE AGENCY CAPACITY

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 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 Vision of MCH & CSHCN is to see all children and families receiving as their right, quality, holistic health care.

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.

Goals & Objectives: MCH & CSHCN 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 underserved 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.

#### Program Capacity:

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.

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. The CQI Team assists in the development of plans and interventions that will support the needed MCH services.

Program staff and our Continuous Quality Improvement (CQI) Team also use their expertise to identify and assess community factors, which may limit the degree of accessibility or availability of MCH services. This is done in conjunction with other community organizations and individuals who also provide similar services to the MCH population.

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.

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 (vacant), one Obstetrician (1FTE), 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. As of June 2009, there were 165 physicians licensed to practice in the territory. This includes sixteen (16) Obstetricians, seventeen (17) Pediatricians and twenty-seven (27) General / Family Practitioners. (Source: V.I. Board of Medical Licensure, 2009).

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. These hi-risk infants are brought in for evaluation with 1 - 3 weeks of being identified. 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 (Part C), Early Intervention program provides Physical therapist, Occupational Therapists, Speech Pathologist and Developmental Specialist to evaluate children that are referred to them by MCH Clinics, Private Physicians, the FQHCs. The Infant and Toddlers Program employs Service Coordinators on each island to handle the assessment of referrals and care coordination of all the eligible clients.

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 with the assistance of a Physical Therapist Assistant on St. Thomas. The Speech Pathologist on St. Thomas may travel to St. Croix to provide services and conduct screening.

Population Based-Services: The MCH & CSHCN Program offers three population-based preventive services: immunization services; the newborn genetic / metabolic screening follow-up program; and the newborn hearing screening program. Each is discussed under related Performance Measures.

Newborn hearing screening continued this fiscal year. Discussion under NPM #12 and SPM #5. Lead screening was initiated on all children receiving care at the MCH Clinics during fiscal year 2009. This will be re-evaluated during fiscal years 2010 and 2011 to determine the need or effectiveness of this test as to date all tests were reported negative. All infants that come into the clinic up to three months of age receive SIDS (Sudden Infant Death Syndrome) counseling by the nurses.

Metabolic / genetic screening for inheritable disorders was expanded to 48 conditions using mass spectrometry. Transition of newborn screening to both hospitals was completed in August 2009. Perkin Elmer Genetics Laboratory continued to provide screening. Follow-up of positive results remain the responsibility of DOH and the MCH & CSHCN Program. Discussion under NPM #1. Collaboration continues with the VI Immunization Program. The goal of the Immunization

Program is to ensure that 95 percent or more of all children living in the Virgin Islands up to age 6 are fully immunized in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations. There are three immunization clinics that administer shots and provide counseling activities on the various types of vaccines administered. The Vaccines for Children (VFC) Program provides vaccines at no cost to children from birth to 18 years who are under-insured or have no insurance, and are covered by Medicaid. Discussion under NPM #7. MCH program regularly receives updates on immunization standards from the VI Immunization Department and the staff also regularly attends in-service trainings sponsored by the Immunization Department.

/2012/ Routine lead screening is initiated for all children at the age of 12 months and data is being collected to determine what the levels are for the children in the territory. SIDS counseling continues as part of the routine nursing intake for all infants. WE CAN (Ways to Enhance Child Activity & Nutrition) program was launched in January 2011. MCH is a WE CAN site. As a site, we partnered with the VI Dept of Education to sponsor several activities within the community to promote healthy nutritional habits and activities that would combat the problems of overeating, unhealthy eating habits and sedentary life. The Head Start program also collected data regarding nutritional intake which is proposed to be used for determining prevalence of obesity problems and the nutritional habits of this population. //2012//

***/2013/ Early identification of developmental delays and sensory impairments -- Training was provided to health care providers, child care providers, and school psychologists on administering the Ages and Stages Developmental Screening Questionnaires. In conjunction with the ECAC, the Department of Education Office of Special Education, the Infant and Toddlers Program, the Department of Human Services- Head Start Program, Early Head Start of Lutheran Social Services and the MCH & CSHCN Program, the Territory held its first annual Children's Health Fair. These community-wide Children's Health Fairs were conducted through interagency collaboration to provide developmental, hearing, vision, BMI, and dental screening, as well as influenza immunizations to children ages birth to five years. The event took place on both districts and screened nearly 100 children under the age of 5.***

***//2013//*** Source: ECAC Annual Report 2011

***/2013/ The parent curriculum for the WE CAN (Ways to Enhance Childhood Activity and Nutrition) a national, evidence-based obesity prevention program that is still being taught at the Parent University ( a Dept of Education initiative to educate parents on various childhood and family issues). //2013//***

***/2013/MCH applied for the State Systems Development Initiative (SSDI) which would provide funds to develop a database that would allow tracking of various performance measures - particularly tracking of the genetic/metabolic disorders. The program was awarded the funding this year (2012) and will utilize the funds to obtain a database that will track the newborn genetic screening results as well as the hearing data. the database will allow interface between the lab that is conducting the test to decrease the time interval between completing the test and obtaining the results. The ability to coordinate efforts of data-sharing should also be improved through these additional funds that will provide more personnel.***

***The MCH program also applied for the Early Newborn Hearing Screening Grant and was also awarded funding for that grant this year (2012). The funds from that grant will increase the program's capacity through increased personnel and more, up-dated equipment to screen and early identify infants with hearing loss so that early intervention services can be provided. //2013//***

***/2013/ Lead screening from the age of 12 months continues within the MCH clinics. The screening of lead is mandatory for all Head Start children as part of their health evaluation for admission to Head Start. The private providers are encouraged to continue to screen for lead particularly in the St. Croix region which is more industrial than the St. Thomas***

**area. The proposal for the development of a Pediatric Environmental Health Unit within the territory should further provide more resources ( personnel and equipment to screen, evaluate and track for lead poisoning.//2013//**

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. Cardiology clinics provide assessment and evaluation of heart disease and provide medical treatment and management. Hematology clinics provide evaluations and family education for children with sickle cell disease, hemoglobinopathies, and follow-up for other hematological disorders such as leukemia.

Orthopedic clinics provide specialized exams, diagnostic procedures, and intervention recommendations for conditions such as scoliosis, and other orthopedic conditions. Diagnosis, treatment and follow-up care for the full range of neurological disorders in children, including comprehensive evaluation and assessment for multiple neurological and/or complex neurological conditions are provided. Comprehensive services for children with known genetic syndromes, including comorbid neurodevelopmental/neurocognitive diagnosis, treatment, and ongoing care are also available.

Shriner's Hospital from Boston sends a group down to the Virgin Islands annually to conduct special orthopedic services free of charge for the children in the territory, and they utilize the MCH clinical area and provide services to the children in the territory with special orthopedic needs, including orthopedic shoes and braces.

Specialty services are offered to all children in the territory regardless of ability or inability to pay.

There is a perpetual shortage of pediatric specialties in the Virgin Islands. The specialists that we have on island serve primarily the adult population. It is not cost effective to send children to Puerto Rico to have general screening for orthopedic concerns or neurologic issues, therefore these sub-specialty pediatricians provide regular valuable services in the territory.

The majority of children referred to the Orthopedist are for evaluation of genu varum, genu valgum and scoliosis. Several of those children have mild cases that should resolve spontaneously; however, there are several that have required special shoes or other devices and need follow up within a few months. It would not be cost efficient to send those children back and forth to Puerto Rico for these types of evaluations. Finances must be reserved for those individuals who require surgical intervention for problems like progressive scoliosis, Blount's Disease, slipped femoral epiphysis, aseptic hip necrosis or even clubbed feet. The post surgical follow up of these patients is done at MCH clinic and not in Puerto Rico.

The ability to have a Pediatric Neurologist available for early screening and evaluation for suspected developmental delay has been beneficial in getting many children into early intervention programs, thus providing good outcomes as compared to the past, where these children diagnosed with a developmental delay in Head Start, hence requiring more intensive therapy. With the Neurologist coming to the territory every 2 months, that still allows for financial resources to be available to help families perform the genetic and metabolic testing required to make a diagnosis for some of the developmental delays noted in these children. With the increased number of premature infants surviving with histories of intraventricular hemorrhages and other usual complications of extreme prematurity, more children are being referred to the Neurologist for evaluation -- all of whom cannot be sent to Puerto Rico. Just as the national numbers for Autism have increased, so have the numbers increased locally requiring neurologic evaluation. The Neurologist collaborates with the pediatricians and the allied health services to create a plan of action for these children. With the formation of the Autistic Spectrum group (Virgin Islands Autism Network-VIAN), a plan of action should be formalized over the next year. /2012/ Despite the lack of pediatric specialists providing services on island due to licensing challenges, the Medical Assistance Program (MAP) was instrumental in providing financial assistance to getting children with special needs to Puerto Rico and Miami for needed services. The MCH Program was able to also provide some limited assistance in this effort.

The program functions with a 1.0 FTE Pediatrician and a 0.3 FTE Pediatrician in the St. Thomas-St. John District, and a 1.0 FTE Family Physician on St. Croix. The lack of adequate medical staff has led to a significant decrease in the number of patients seen annually with an average wait of six months for appointments. //2012//

***/2013/ MCH partners with MAP and has a referral system and follow-up for those Medicaid patients that require specialized Pediatric services. The patients are sent to Puerto Rico to the Pediatric Specialist through MAP funding ( MAP clients) and a report of the findings is provided to the MCH referring physician via e-mail from MAP.***

***Enabling Services: Translation services at clinics are available through bilingual staff for Hispanic-Spanish speaking clients and French-dialects from the eastern Caribbean islands. Transportation services are not routinely offered but can be arranged with the administrative office. Off-island air transportation may be provided based on need and availability of funds. Home visitation is conducted on a priority basis for high-risk populations. Nutrition services are offered by Women, Infant and Children's Program (WIC).***

***There was a noticeable, though not documented, increase in the number of uninsured children of undocumented families who have not met the residency or other legal requirements to apply for medical assistance, or who would not otherwise receive health care, seeking health care and sub-specialty health care through the program. Provision and delivery of these services enabled high risk populations to establish relationships with the health care system.***

***Discussions continued with private group medical practices and the hospitals to get a complement of Pediatric Specialists to serve the Pediatric Population within the territory. We are currently discussing the implementation of a referral system with fee for service once the Specialists are recruited and hired. The DOH is also looking at the feasibility of Telemedicine as another option to provide Pediatric Specialty care.***

***Nevertheless, by partnering with many of the community based organizations such as VI Perinatal Inc., VI PUSH, and VI FIND -- all organizations that provide support services, training information, and resources to parents, health care providers, and schools, we have been able to enhance our outreach efforts to educate our clients as well as leverage our resources to provide family support services. Our continuous efforts to educate our clients within the clinic setting has improved as evidence-based medicine guidelines are easily accessible via internet linkage to the AAP website and CDC website.***

***An awareness campaign about Fetal Alcohol Syndrome (FAS) was launched throughout our community by placing posters/brochures with information about FAS in our prenatal clinics, Pediatric Clinics and within the Family Planning Clinics. Within the prenatal clinics, screening efforts have increased by assessing and documenting the amount of alcohol that each pregnant female consumes to identify these pregnancies as high risk pregnancies for FAS. This practice of documenting alcohol use during pregnancy is also done by the Pediatrician who is present at the delivery of the infant as a backup measure to identify high risk pregnancies for FAS.***

***As a member of the Early Childhood Education and Care Committee (ECAC), MCH has partnered with other agencies that are a part of the Committee to devise methods to incorporate education and awareness of FAS as a part of the early childhood workers' training in order to increase early identification of children with FAS.***

***/2013/ Program staff participated in several health education and outreach activities in collaboration with community organizations. FAS Awareness Campaign continued in the Prenatal Clinics using posters and brochures with screening for alcohol use during prenatal visits through self-disclosure. Division of Mental Health and Substance Abuse sponsored a major conference on Fetal Alcohol Syndrome in April 2011. MCH Program collaborated with COAST (Council on Alcoholism--St. Thomas) and participated in panel discussions on Alcoholism in April 2011. Sponsored safety discussions (seat belt safety,***

*playground safety, fireproofing your home) for clients during Public Health Week in April 2011. Collaborations continue with WIC for nutrition counseling for children in the MCH clinics that are underweight, overweight or obese. TEXT 4 BABIES, the educational and support system for pregnant mothers throughout their pregnancies, was launched in the prenatal clinics and MCH clinics as a joint venture between the First Lady (Cecil DeJongh), ECAC and CFVI. In-service for school staff (school nurses, special education teachers, school principals) on Diabetes in children and the Youth Ambassador Program for Diabetes continued throughout the year. //2013//*

*/2013/ Text4baby was successfully launched in both districts in collaboration with the Governor's Early Childhood Advisory Committee and the Community Foundation on the Virgin Islands. Text4baby is a free mobile information service that provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life. Women who sign up for the service receive free text messages each week, timed to their due date or baby's date of birth. These messages focus on a variety of topics critical to maternal and child health, including birth defects prevention, immunization, nutrition, seasonal influenza, mental health, oral health and safe sleep. Text4baby messages also connect women to prenatal and infant care services and other resources. The USVI project has been nationally recognized for the number of women enrolled in the territory.*

*//2013// Source: ECAC Annual Report 2011*

*/2013/ The VI Autism Network (VIAN) continues to work within the territory to provide health care providers and parents with information and updates regarding Autism. Their mission is : To bridge the awareness gap in the Territory of the Virgin Islands for children and their families dealing with Autism Spectrum Disorders (ASDs); to provide educational resources; to facilitate early diagnosis and to raise funds for the mission, by collaborating with public and private sectors, both locally and globally. VIAN has 8 Board Members and 2 Parent Coordinators; chairs a Monthly Parent Support Group; is a project of the Saint Croix Foundation; and sponsors the Annual Conference on Autism & ABA (Applied Behavior Analysis) training workshops. the use of Applied Behavior Analysis (ABA), also known as behavioral intervention or behavioral treatment, utilizes methods based on scientific principles of behavior to bring about comprehensive and enduring improvements in a wide range of skills for most children with Autism, ADD/ADHD and late talking children. This home or school based therapy serves to improve the lives of children on the Autism spectrum. Many of the staff members of the MCH program participated in this annual training and conference. Due to limited funding, the work in Autism has been reduced to the annual conference and parental support group. In addition to having fund-raisers, the Autism Network continues to partner with other organizations, particularly VI University Center for Excellence in Developmental Disabilities (VIUCEDD), to leverage resources and sponsor these conferences and support groups.*

*In 2011, Governor John P. de Jongh, Jr. had proclaimed the month of April, 2011 as "Autism Awareness Month" in the U.S. Virgin Islands to increase awareness and further develop knowledge of the global autism epidemic and to impart information regarding the importance of early diagnosis and early intervention. //2013//*

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. Access to staff development activities, training and technical assistance to assure continuous quality of care was provided. Improvement in data collection activities for monitoring and evaluation of services to this population was undertaken during this fiscal year. Challenges remain with a lack of adequate data linkages and child health information systems to support program activities including data collection and analysis. Program policy and procedures manual is revised to address the need for standards and guidelines for service provision, data collection, training and quality assurance / improvement.

Planning activities directed at addressing infrastructure and development of a comprehensive continuous quality improvement plan to assist in building organizational development and system capacity were initiated in FY 2008 and resulted in the formation and development of a Continuous Quality Improvement (CQI) Team within the MCH Program structure. The CQI Team continues to assist with the development and implementation of strategic plans to improve coordination and integration of MCH services; assist MCH leadership and management in the development and implementation of a comprehensive CQI plan to ensure ongoing assessment, program planning, evaluation processes and practice; and improve ability to develop and conduct 5-year needs assessment. Technical Assistance from MCHB was awarded for the crucial CQI activities.

In the area of workforce development, a two year program - Leadership Education and Developmental Disabilities (LEADD, was started in September 2007. The program was presented by the Westchester Institute for Human Development and the School of Public Health, New York Medical College in partnership with the VI University Center for Excellence in Developmental Disabilities (VICEDD) at the University of the Virgin Islands (UVI); and funded by a grant from MCHB. LEADD broadens the opportunities for continuing education and leadership development available to MCH, health and other professionals in the VI, especially as related to children with developmental disabilities and their families. The program uses blended learning distance education methods which combines live classes, computerized virtual classroom instruction, online discussion and self-study. Individuals registered in this four-semester, two-year program graduated in December 2009 and received academic credits offered by the School of Public Health, New York Medical College. Courses were taught by faculty from the Westchester Institute of Child Development and included major topics of current interest, introduction to the public health perspective, understanding and addressing health disparities and cultural competence, family-centered care, distinctive concerns of the Caribbean and Virgin Islands, leadership and genetics and other specific topics.

/2012/ The CQI team is developing model programs for health care delivery, assessing and revising current policies and procedures to create standard, evidence-based health care practices. //2012//

***/2013/ MCH staff continues to be very involved in activities surrounding and supporting systems of care for early childhood. Staff assisted in the development of a Quality Rating Improvement System (QRIS) for the Department of Human Services and drafting Infant and Toddler Guidelines as active participants in the Professional Development and Quality Education workgroups of the ECAC:***

***Early Learning Guidelines -- In order to improve the quality of care and education focused on school readiness and to provide a common set of preschool standards across all settings, a team of USVI professionals developed the Virgin Islands Early Learning Guidelines, published in April 2010. The Guidelines reflect what children need to know, understand, and be able to do by the time they reach kindergarten with suggestions for parents and teachers for supporting children's development and learning. The Guidelines are meant to be inclusive of all children and settings in which young children spend time before kindergarten. Domains addressed include: Physical Health and Development; Social, Emotional and Values Development; Approaches to Learning; Language and Literacy; Mathematics; Science; Social Studies; and Creativity and the Arts. Work Group members are currently drafting Infant and Toddler Developmental Guidelines expected to be published in 2012.***

***Quality Rating and Improvement System (QRIS) -- A QRIS is a method to assess, improve, and communicate the level of quality through a uniform approach across early care and education settings. The QRIS provides a mechanism to align and coordinate the implementation of territory-wide quality improvement initiatives, including improved health and safety practices, professional development, Strengthening Families, and Early Learning Guidelines in a way that also provides support to center staff. It is anticipated that the USVI QRIS will be ready for implementation in the spring of 2012. Entry into the QRIS will be voluntary. Centers achieving licensure according to the revised Child Care Rules and Regulations have the option to enter at the first level. Subsequent standards***

***and levels of quality have been identified and are built upon licensing standards. //2013//***  
Source: ECAC Annual Report 2011

## **C. Organizational Structure**

### III - C. ORGANIZATONAL STRUCTURE

The MCH & CSHCN Program is a unit within the Department of Health, one of 14 government departments. The Department of Health is headed by the Commissioner of Health. The Department of Health was reorganized in February 2010. The executive staff consists of the Commissioner of Health, Administrator for Policy and Program Planning, Deputy Commissioners for Divisions of Public Health Services, Fiscal Affairs, Administrative Services and Management and Health Promotion and Disease Prevention.

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 open communication 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. The agency is committed to building a sound policy and program infrastructure that reflects the twenty-first century. 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.

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 Maternal and Child Health and Children With Special Health Care Needs Program reports directly to the Deputy Commissioner for Public Health Services. The MCH & CSHCN Program is operated as a single organizational unit and 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 Administrative Unit is composed of the Director for MCH & CSHCN, Assistant Director, Program Administrator, Territorial Financial Manager (this position was vacated in May 2010. Recruitment is underway), and Office Manager.

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, Assistant Director and Program Administrator are ex-officio members. The Advisory Council was revitalized in 2003 with the election of a dynamic chairperson who played a major leadership role in revision of the By-Laws of the Council. Several committees were formed to address issues and challenges within the program including program evaluation, quality improvement, public awareness and family participation. Members of the council also served on the ad hoc committee for the five-year needs assessment. Council members are instrumental in review of the Block Grant narrative and provided valuable input.

Due to limited resources, the Council was unable to have a joint inter-island meeting this past fiscal year. However, individual members have reviewed and provided input on the draft 2010 needs assessment instrument and approved the Adolescent Health questionnaire in its current form. Members also volunteered to form a core group for review of the Block Grant application

and as facilitators for proposed focus groups for both surveys.

**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's mission is to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations. STEEMCC's goals are to eliminate barriers and health disparities, assure access to quality care, and improve the health care infrastructure. Primary and preventive health care strives to address the current disparities in health care by providing accessible high quality, appropriate, affordable, family oriented, comprehensive primary and preventive health care services to individuals, families and the community at large.

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.

The Division of EMS has established a training facility in the St. Thomas-St. John District. The VI-EMS was awarded a \$345, 000.00 Grant for the period March 2006 -- February 2009. This grant specifically seeks to promote the development of children specific EMS policies and procedure in the territory.

Funding from this grant has been used to: support an EMSC Advisory Committee; attend mandatory grantee meetings; provide pediatric and trauma education for EMS personnel; finance the development and printing of EMS Policy Manuals and purchase equipment to assist with proposed plans to transition the division from paper to electronic records. VI-EMS was able to acquire a customized Mass Casualty Management System Trailer. This Mass Casualty Incident Trailer will be used for any type of incident whether manmade or natural disasters. The funding source was through the Office of Homeland Security.

***An attachment is included in this section. IIIC - Organizational Structure***

## **D. Other MCH Capacity**

### **III - D. OTHER CAPACITY**

**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. These trainings have been accessed by many of the MCH clients and have been significant in educating parents about their rights and empowering them to receive additional support for their families.

**Health Planning:** The Bureau of Health Planning is charged with the regulatory responsibility of administering the Certificate of Need (CON) program established by Title XIX of the Virgin Islands Code. The Bureau's mission is to guide the establishment of health facilities and health services by administering a CON program that will best serve the needs of Virgin Islands residents. The fundamental premise of the Certificate of Need (CON) program is to restrain the ever-increasing health care costs; prevent the unnecessary duplication of health care facilities; and finally to achieve equal access to quality health care at a reasonable cost.

**Office of Primary Health Care:** The mission of the Office of Primary Health Care (OPHC) is to increase access to primary health care for all US Virgin Islands' residents, regardless of ability to pay.

It's vision is to educate the population by increasing health consciousness in the Virgin Islands relative to reducing health disparities, increasing access to health care, and developing strong ties with health partners in addressing public health education opportunities.

The OPHC's goal is to address healthcare workforce shortages in the US Virgin Islands through collaborations with national and local healthcare decision-makers, stakeholders, and professionals.

Primary objectives of the OPHC are:

1) To facilitate Health Professional Shortage Area (HPSA) and National Health Service Corps (NHSC) site designations for all qualified health centers and clinics.

2) To coordinate the NHSC program, which includes, providing assistance with recruitment and retention of healthcare professionals and serving as a NHSC ambassador to promote and fill healthcare provider vacancies in the US Virgin Islands

The Virgin Islands Primary Care Office (VI PCO) is federally funded by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BHPC), Bureau of Clinician Recruitment and Services, and Bureau of Health Professions (BHPPr).

**Office of Vital Records and Statistics (VRS):** Vital Records and Statistics collect, analyzes, and

disseminates vital events data in the territory. The program works with the courts, healthcare facilities, the University of the Virgin Islands and other agencies involved in births, deaths, marriages and divorces. Its mission is to ensure the registration of live births, deaths, and other vital statistics in the territory.

As Vital Records and Statistics is the key agency in the Department of Health for correlating health related statistics, its vision is to create an environment conducive to the delivery of information necessary for the planning and delivery of quality health care.

Vital Records and Statistics is committed to maintaining accurate health data and vital statistics of the US Virgin Islands to divisions within the Department of Health, the Virgin Islands community and the National Center for Health Statistics.

This office generates the health statistics, leading causes of death and maintains a cancer registry for the Virgin Islands. Due to technical and managerial personnel shortages, this office remains limited in its capacity to analyze data.

Health Information Technology (HIT): This office is responsible for evaluating and recommending hardware and software for the various programs/divisions. Responsibilities include: installation, maintenance, training and ongoing support of all computer and communication systems. Additional functions include research and development of new applications for technological advancements, which can reduce costs while improving efficiency. The goal of HIT is to automate all programs/divisions within a comprehensive network for electronic data sharing and telephone interconnects via a technologically advanced communication network. Internet access, E-Mail, data sharing, and an Integrated Health Information System for all clinics are provided through this network.

Family Planning Program: Family Planning is authorized by Section X of the Social Security Act. The V.I. Family Planning Program was initiated in 1979 to support the provision of voluntary services primarily to low income persons. It serves as a point of entry into the public health system to women at risk for unintended pregnancy, sexually transmitted diseases including HIV/AIDS, and in need of primary care services. Outreach services intended to encourage healthy behaviors among Virgin Islands families especially adolescents is also a vital component of this program.

The mission of the Family Planning Program is: "To promote optimal health in our community, in the full understanding of the culture, habits and needs of our community, by assisting and counseling individuals, mainly women of childbearing age, and families to achieve the goals they have set for family size; by promoting healthy sexual attitudes and behavior, and by improving adolescents understanding and attitudes about human sexuality and contraception". The program provides: medical evaluations, human sexuality and contraceptive counseling, infertility management, genetic counseling, and social, nutrition, and health education referrals. The Family Planning Program's accomplishments are related to its mission to provide affordable, culturally sensitive educational, counseling and comprehensive medical and social services necessary to enable individuals, mainly women of childbearing age, to freely determine the number and spacing of their children, help reduce maternal and infant mortality and promote the health of mothers and children

VIFPP 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.

Virgin Islands Perinatal Incorporated (VIPI): VIPI was recognized as a tax-exempt 501(c) (3) in 2003. VIPI is a model for consumer involvement. The "Promoting Health Families Initiative" and

"Healthy Families...Healthy Babies Initiative" provide community-based health education, outreach services and case management for high-risk pregnant women, diabetic and hypertensive individuals and their families. The main focus of these initiatives are to decrease the rate of pre-term births, diabetes and hypertension, and promote awareness for breast, cervical, prostate and colorectal cancer. This is a community driven project to promote healthier families in the VI with the outcome of a stronger and healthier community. The target population is low-income, uninsured/ underinsured and underserved families. Family Outreach Educators, Care Managers and Prevention Specialists conduct activities to ensure that enrolled clients have access to health care services in a medical home. VIPI instituted the Perinatal Morbidity & Mortality Review Committee (PMMRC) based on the National Fetal & Infant Mortality Review (NFIMR) model to determine the common clinical indicators leading to preterm births and fetal deaths. PMMRC activities have progressed over the past fiscal and calendar years. Data collection and audits of medical charts at Juan F. Luis Hospital on St. Croix was completed and a report summarizing the audit findings was completed and circulated among local healthcare stakeholders. As of January 2010 data collection from medical records at Schneider Regional Medical Center on St. Thomas was underway. This will be completed by July 2010 followed by the finalization of a Territorial Perinatal Morbidity & Mortality Review. In December of 2009, VIPI applied for a federal grant to publish the findings of the review and to host a conference locally to outline these findings and determine the common clinical indicators leading to preterm births and fetal deaths.

The Healthy Families... Healthy Babies Initiative expanded to the St. Thomas-St. John District in FY 2006 and currently provides services at the VIDOH Community Health Clinic site and the St. Thomas East End Medical Center to include Spanish medical interpretation. VIPI continues to provide services to low-income, uninsured, under-insured high risk pregnant women. 187 women and their families were served since the program's inception on St. Thomas. 71 were served on St. Croix from October 2008 to December 2009.

Due to the rising cost of health care and the growing undocumented population in the territory VIPI established a workgroup to evaluate local capacity, create a local border health frame-work and conduct efforts for policy development. Efforts to collect data & quantify trends of non-citizens usage of local public health resources were made. It was proposed that available Border Health resources be identified to assist in addressing the financial and systemic burden placed on the territorial resources. Discussions focused on the territory's ability to continuously and effectively respond to the health care needs of non-citizens. As of June 2009, VIPI Border Health Coordinator met with the Virgin Islands Delegate to Congress Donna M. Christensen to highlight this growing trend and obtain suggestions on federal policy with regards to the territory gaining border health certification. With invaluable guidance from the Delegate to Congress, VIPI and its major stakeholder, Schneider Regional Medical Center met with representatives from the Office of Insular Affairs (OIA). This agency oversees administration of several United States possessions/territories (Marshall Islands, Guam, USVI, etc.) and administrative responsibility for coordinating federal policy in the territories and oversight of federal programs and funds. The meeting was productive and provided valuable input into the workgroups efforts to pursue designation as a Border Territory.

/2012/ At this time, VIPI is currently pursuing new initiatives to include the following: (1) participation in national Patient Assistance Programs with Pfizer, Novo Nordisk, Johnson and Johnson, and Bristol, Myers and Squibb to address to growing pharmaceutical needs of its clientele (2) facilitating discussions with local high school heads and vested health professionals to outline feasible and effective methods to prevent teen pregnancy and (3) seeking new funding opportunities to support and sustain services to the Virgin Islands most needy families.//2012//

/2012/ Home visiting programs aim to help families support their children's healthy growth and development. These programs may target their services to families or caregivers who are at a particular disadvantage when it comes to establishing and maintaining such a supportive environment, or where the child is more vulnerable due to health or developmental concerns. On March, 23, 2010, the Patient Protection and Affordable Care Act was signed into law. The Act included amending Title V of the Social Security Act by adding Section 511 titled "Maternal,

Infant, and Early Childhood Home Visiting Programs? (MIECHV). The MIECHV Program is administered under the Division of Child, Adolescent and Family Health of the Health Resources and Services Administration (HRSA). It is a collaborative grant that aims to strengthen and improve the programs and activities carried out under Title V programs, as administered under the Division of State and Community Health of HRSA. The intent of the MIECHV Program is to improve coordination of services for at-risk communities and identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. Under the guidance of the Health Resources and Services Administration in conjunction with the Administration for Children and Families, the overarching goals of this initiative are to promote: improvements in maternal and prenatal health, infant health, and child health and development; increased school readiness; reductions in the incidence of child maltreatment; improved parenting related to child development outcomes; improved family self sufficient; improved socio-economic status; greater coordination of referrals to community resources and supports and reductions in crime and domestic violence. //2012//

***/2013/ VIPI's Health Families Healthy Babies Initiative implemented effective interventions among its clientele to produce healthy birth outcomes in 2011. Of the fifty-two (42) births reported for the 2011 calendar year, 85% (36 births) resulted in normal term babies. Six births (14%) resulted in pre-term births and 1 pregnancy ended due to fetal demise.***

***Additionally, there were 34 home visits conducted last year to support and/or educate these women and to promote compliance with their respective treatment plans. All-in-all, the HFHBI continue to provide valuable services to VIPI's clientele. //2013//*** Source: VIPI HFHBI 2011 Annual Report

***/2013/ During the calendar year, January 1, 2011 to December 31, 2011, PHFI served a total 290 clients, 258 females and 32 males. Of this number 94, or almost 33% were high risk pregnant clients, with 70% entering prenatal care in the second or third trimester. During this period, 66 babies were born and 1 miscarriage occurred. 89% were normal birth weight and 80% of the 66 births were vaginal, with 20% delivered by caesarean section. Gender breakdown showed 36 females and 30 males birthed to this group. 82% of new mothers initiated breastfeeding, and 59% continued to breastfeed for the 1st three months. This sharp rise in breastfeeding Moms can be attributed to program investment in breastfeeding classes for pregnant program enrollees as well as the larger pregnant population on St. Croix and St. Thomas. The agency plans to continue promoting breastfeeding and will launch a social marketing campaign in the coming year to educate the community about breastfeeding benefits. A total of 178 house visits were made for the 94 pregnant program enrollees. //2013//*** Source: VIPI PHFI 2011 Annual Report

## **E. State Agency Coordination**

### **III - E. STATE AGENCY 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.

Infant and Toddlers Program: The Early Intervention program for Infants and Toddlers with Disabilities was established under PL 99-457. Locally, under the division of Public Health services through executive order of the Governor, the Virgin Islands Department of Health (VIDOH), as the lead agency ensures that the Infants and Toddlers Program (ITP) maintains a territory-wide, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families. In accordance with CFR 34 303.124 early intervention services provided through the Infants and Toddlers Program supplement, but do not supplant, state and local funds expended for children eligible under this part and their families. The overall goal of the program is to enhance the capacity of families to meet the special needs of their children.

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.

ITP's collaborative efforts with and close physical proximity to the MCH & CSHCN Program are especially effective via its Child Find activities. The program contributes its success to its continued efforts to maintain early referrals to the program. Private physicians, hospitals, other public clinics, and child care centers are visited and Part C program information shared and disseminated. The program issues a written notice on receipt of the referral to the primary referral source and provides feedback that indicates if the child is eligible. Early intervention services are rendered in the Part C of IDEA eligible child's natural environment and are provided during the early weekday evenings and on Saturdays, in addition to the work week times. Other collaborations are being initiated to increase early identification and referrals, and maintain rapport with primary referral sources, such as hospitals, clinics and private physicians. Representatives from the program periodically visit with private pediatricians in their offices thanking them for referrals and presenting a clear and concise message of the benefits. ITP will continue current efforts to maintain a comprehensive child find system and continue monitoring referral sources and current outreach efforts.

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.

***/2013/ In response to the need to improve coordination and collaboration among public and private entities focused on the care and education of young children, the federal government mandated the creation of state early childhood advisory councils through the Improving Head Start Act of 2007. Through Executive Order #440-2008, Governor John P. de Jongh, Jr. established the Virgin Islands Early Childhood Advisory Committee (ECAC)***

**as a standing committee of the Children and Families Council and pursuant to the Improving Head Start Act of 2007 on June 2, 2008. The Community Foundation of the Virgin Islands of the Virgin Islands (see below) has been funded to coordinate the activities of the ECAC. Membership of the ECAC includes representatives from public and private agencies involved in activities and/or services or with an interest in the welfare of young children and families. The ECAC operates under the following vision, mission, and goals.**

**Vision: All children in the VI thrive, grow, and learn in safe, nurturing, healthy families and communities.**

**Mission: To develop a high-quality, coordinated, sustainable system of supports and services for young children and their families so all children begin school safe, healthy, and ready to succeed.**

**Goals:**

- 1. Governance and Financing: All sectors are engaged in creating and sustaining collaborative structures to ensure an effective early childhood system**
  - 2. Health and Wellness: Children are healthy and ready for learning.**
  - 3. Quality Education: Children and families have increased access to high quality educational opportunities in nurturing environments.**
  - 4. Professional Development: Individuals who work with and/or on behalf of children and families have access to a comprehensive coordinated cross-sector professional development system**
  - 5. Strengthening Families: Families have resources and supports they need to promote their children's optimal development //2013//**
- Source: ECAC Annual Report 2011

Mental Health Services: Pursuant to Title III, Section 418, of the Virgin Islands Code the Department of Health is designated as the single State agency for mental health, alcoholism and drug dependency. The Division of Mental Health, Alcoholism, and Drug Dependency Services ("DMHADDSS") is the agency charged with establishing and administering programs designed to offer prevention and treatment intervention services in the areas of Substance Abuse Prevention, Substance Abuse treatment, Mental Health, and Residential Services. Services are offered territorially at four (4) out-patients clinic sites and one residential facility.

Mental health services to children include evaluation, assessment, and therapy. Psychological services are routinely provided only in the STT district. In the STX district where the bulk of the cases are, services routinely are provided by a psychiatrist and a MHW III (child and family therapist).

Data reported for FY 2009 shows that this activity center provided services to 110 children ages 1 -- 17. These services included individual, family and group therapy; monitoring of medication and psychiatric evaluations.

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. This is accomplished by providing a continuum of educational opportunities through which the student in Inclusive Early Childhood Education may earn a Certificate, an Associate of Arts Degree, and a Bachelor of Arts Degree.

The primary goals of VIUCEDD are to: demonstrate exemplary approaches in clinical, educational and community settings; provide technical assistance to community and educational entities; disseminate information related to the implementation of evidence based practices; ensure participation of persons with disabilities and their families in the design and implementation of all VIUCEDD activities ; collaborate and coordinate activities for families with

children with disabilities that promote their independence, self advocacy and integration into the community; provide training on the laws that protects the rights of persons with disabilities and their families; and provide training to schools regarding the school wide issues on positive behavior supports and inclusive practices.

The unique nature of working with young children implies that professionals develop the skills necessary for working with and collaborating effectively with families and other professionals. A broad knowledge of development and learning from birth through age eight is necessary for educators to provide appropriate curriculum and assessment approaches. The fact that not all children develop at the same rate and children with developmental delays and disabilities are included in typical early childhood classes requires that professionals have knowledge of an even wider range of development and learning. In response to this challenge, the Inclusive Early Childhood Education (IECE) Program at the University of the Virgin Islands was created. The program design is a product of a local task force. In their work, the task force drew on the recommendations and guidelines of national legislation and standards for teaching and professional development established by national organizations which reflect research and recommended practices in Inclusive Early Childhood Education. The program is designed to ensure that students learn about the variability of young children and the adaptations and modifications that can be made to ensure typical development and learning experiences for all children. The program stresses the importance of natural environments, play support, and the integration of developmental and learning experiences into the curriculum. Students are trained to assume the primary role of facilitators of child development and learning and parent-child relationships.

VIUCEDD also offers American Sign Language courses during the fall and Spring semesters, and technical assistance to community groups serving individuals with disabilities. An Assistive Technology degree is offered as an option within the Masters of Education program at UVI. Courses are taught by visiting faculty from the Graduate School of Health Sciences at New York Medical College and the Westchester Institute for Human Development University Affiliated Program. The VI Assistive Technology Foundation (VIATF) offers persons with disabilities access to low-interest bank loans to purchase assistive technology (AT) devices and services. Under VIATF, the cost of the borrowed money is significantly reduced. Any Virgin Islands resident who has a disability and/or any family member or guardian of a person with a disability can apply for the loan. The applicant must satisfy the standard bank loan requirement which is mainly the ability to repay the loan.

**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.

**Summary of Service Delivery: Disabilities & Rehabilitation Services**

**Basic Grant:** Under this grant, vocational rehabilitation services conducts assessments for determining eligibility, provide counseling, guidance, and referral, physical and mental restoration services, coordinates vocational and college activities and on-the-job training and transportation for individuals with disabilities. Additionally, it coordinates and funds support services which include: interpreter services for individuals who are deaf, reader services for individuals who are blind, services to assist students with disabilities transition from school to work, personal assistance services, rehabilitative technical services and devices, supported employment and job placement services. In fiscal year 2009, the program provided services to 74 persons under 19 years of age, and 44 persons 20 years or older. Data on gender, race and ethnicity is not available.

(Source: DHS Annual Report FY 2009)

Developmental Disabilities: 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. In the Virgin Islands, the Department of Human Services administers the Developmental Disabilities Program through its developmental services component. The developmental services component provides grants to public and private non-profit organizations that provide services such as legal advocacy, employment, training, and special transportation. The Developmental Disabilities Council advises the Department of Human Services in the performance of these functions. The Title V MCH & CSHCN Program Director is appointed to the Council by the Governor of the Virgin Islands.

***/2013/ The MCH & CSHCN Assistant Director now actively serves as the Title V representative for this Council after appointment by the Governor of the Virgin Islands. //2013//***

Women, Infants and Children Program: The WIC Program is administered by the United States Department of Agriculture, Food and Nutrition Service, through Section 17 of Child Nutrition Act of 1966, as amended. The program serves as an adjunct to good health care during critical times of growth and development, in order to prevent the occurrence of health problems, including drug and other harmful substance abuse, and to improve the health status of women, infants and children. The program provides supplemental foods and nutrition education.

The VI WIC Program is 100% federally funded and is administered by the Department of Health. The purpose of WIC is to serve as an adjunct to preventative health care services during critical times of growth and development, in order to promote and maintain the health and well being of nutritionally at-risk women, infants and young children. Persons eligible for the program include pregnant, breastfeeding and postpartum women, infants and children up to age five who are determined by a health professional to be at nutritional risk and meet income criteria. WIC promotes breastfeeding as the optimal infant feeding choice unless contraindicated.

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 breastfeeding rate among WIC post-partum participants was maintained. Exclusive breastfeeding rate is at 3%. See discussion under NPM # 11 & 14.

Nutrition Services within the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are provided to improve the nutritional status of its target population. These services are provided at no cost to the participant as defined in federal regulations [246.11(a) (1)]. The Virgin Islands WIC Program accordingly, provided nutrition education, supplemental foods, food demonstrations on ways to use WIC foods, and referrals to other health and social services agencies. Nutritionists provided high-risk nutrition education contacts to WIC participants. VI WIC provided nutrition and clinical services to approximately 5,568 participants in FY 2009. See discussion under Performance Measure # 11 & 14.

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.

Community Foundation of the Virgin Islands (CFVI): CFVI was created to serve both donors and nonprofit organizations of the Virgin Islands that want to ensure the highest quality of life for both present and future generations. Its primary goal is to build a collection of permanent funds, which will be used to enhance the educational, physical, social, cultural and environmental well-being of the children, youth, and families of the Virgin Islands. CFVI funds several programs and initiatives including Voices for Virgin Islands Children whose mission is to promote the well-being of and empower children, youth and families in the US Virgin Islands through research, media outreach, public education and legislative advocacy. In addition, it seeks to involve the community as non-partisan, nonprofit advocates for children's needs and rights.

The KIDS COUNT USVI Data Book provides information on child well-being in the U.S. Virgin Islands. Its purpose is to promote dialogue on children's issues, and to stimulate community response to improve the health, safety and economic status of VI children, from birth to age eighteen. USVI KIDS COUNT is part of a national initiative, sponsored by the Annie E. Casey Foundation, to create a detailed community-by-community picture of the condition of children nationwide. There are now KIDS COUNT projects in all fifty states, the District of Columbia, Puerto Rico, and the US Virgin Islands. Since 2000, the KIDS COUNT USVI Data Book has been compiled and published each year by the Community Foundation of the Virgin Islands (CFVI), serving the needs of the territory's children, youth, and families.

Another initiative, The Family Connection (TFC) has built a cutting edge resource library with more than 250 professional titles on early literacy, curriculum, child psychology, and the business management of child care centers. Additionally, TFC center offers a lending library with more than 1,000 developmentally appropriate toys and children's books. Over 150 parents, child care providers, teachers and university students are regular visitors to the TFC Center. TFC is the leader in early child care professional development, providing early childhood social and emotional workshops as well as early literacy workshops in the USVI territory. TFC also frequently reaches out to community groups to provide training by request. The TFC Center has become an important space for the early childhood community to gather and share ideas on raising the standard for high-quality care in the U.S. Virgin Islands. TFC has expanded its services with weekend and evening hours, an increase in staff, and a new center in development on St. Croix. TFC continues to reach out to the early childhood community by offering impact grants of up to \$5,000 for early childhood education initiatives.

The Family Connection (TFC) introduced Born Learning, a public engagement campaign focused on the importance of creating early learning opportunities for young children. The goal of Born Learning is to make lasting community change through building public awareness, education and community action. Born Learning was created by the national United Way, and is endorsed by our local United Way agencies. TFC produced three localized Born Learning radio spots to teach parents how to make every day moments learning moments. TFC staff made guest appearances on radio shows to spread the word and raise awareness about the importance of Born Learning in the community. TFC also made Born Learning presentations and distributed learning materials Territory-wide at professional development and parent orientations. TFC expanded the Born Learning campaign to businesses, private childcare centers, and doctors' offices. CFVI opened the first Born Learning Trail in the Territory located at Magens Bay. The trail includes 10 signs designed to assist parents and child care providers with creative ideas on communicating and interacting with their children.

/2012/ CFVI had a retreat in December 2010 to review their accomplishments and to start working on a strategic plan. They ended the year with assets of over \$7 million from 1.7 million at the end of 2000. They had an annual giving of \$2 million in grants, scholarships, and services. The total giving to date is in excess of \$9 million. The Family Connection, CFVI's response to KIDS COUNT, is leading the community in improving early childhood experiences for the children

in the territory.

Future plan is to continue to build assets and invest in the future of the children in the territory by enhancing their growth and development. //2012//

Medicaid Program: The Bureau of Health Insurance and Medical Assistance is the agency within the Department of Health responsible for the administration, planning and coordination of Title XIX (Medicaid), which is a fixed, capped grant, and Title XXI (Child Health Insurance Program or CHIP). The Virgin Islands State Plan for Medical Assistance was approved by the Department of Health and Human Services (formerly Health, Education and Welfare) and has been in operation since 1966. The mission of the Medical Assistance Program is to assure that health care is readily available and accessible to all eligible low income persons and that the care is of high quality, is comprehensive and continuous. To fulfill this mission, the Program must:

- Assure that clients have access to necessary medical care
- Assure that the quality of care meets standards
- Promote appropriate use of services by clients
- Promote appropriate care by service providers
- Assure that the services are purchased in the most cost-effective manner.

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.

Child Health Insurance Program: Title XXI of the Social Security Act was enacted August, 1997 and provides 24 billion dollars over five years to insure millions of American children in families at or below 200% of poverty for children not eligible for Medicaid or other public or private insurance. The Child Health Insurance Program (CHIP) is administered by the Bureau of Health Insurance and Medical Assistance. The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS because Congress did not approve enough CHIP monies for the territories that would have allowed them to have a regular Child Health Insurance Program. These limited funds were used to pay already incurred medical bills for Medicaid children whose federal Medicaid funding were expended by the end of the fiscal year.

Due to the limitations of the statutory cap and inadequate funding levels, VIDOH has been unable to address the health care needs of uninsured children. Limited S-CHIP funds are combined with MAP to provide health care for Medicaid eligible children. MAP funding in the territory is evaluated based on household income and is not age specific. To qualify children must reside in a household with annual income less than \$9,500 per year (family of 4) which is less than half of the federal poverty level. Even with combining these funding sources VI is unable to provide health care assistance to all eligible children in this very low income range.

## **F. Health Systems Capacity Indicators**

## NARRATIVE SUMMARY FOR FY 2013 HEALTH SYSTEMS CAPACITY INDICATORS:

### Introduction:

The Title V Guidance requires all States and jurisdictions to report annually on selected Health System Capacity Indicators (HSCI) that assess the capacity of the health care system to address the needs of the MCH population. HSCI primarily assess how well state programs such as Medicaid, SCHIP, and CSHCN are meeting the needs of those eligible for such services. In addition, they assess Title V programs' ability to access relevant data sources and linkages. Since these HSCI's measure services provided through Medicaid, SCHIP and SSI, it must be noted that allotments to the Virgin Islands are capped and SSI is not available. The current system does not have an adequate data and information structure to obtain valid, reliable data to respond to these indicators. An integrated data system has not been realized. The availability of information based on valid, accurate and measurable data which is an important requirement for the analysis and objective evaluation of the effectiveness of the Title V remains unattainable. Some data is obtained for most of the Health System Capacity Indicators through a variety of sources, but primarily through the DOH Vital Records & Statistics birth and death certificates, DOH STD/HIV Program, hospital admission records, Office for Highway Safety, and VI-EMS.

### Health System Capacity Indicator #01:

Asthma is not only a common condition among children in the VI, but is also a significant cause of morbidity and mortality in children. The environmental hazards that exist in the territory such as industrialized pollutants from the factories and refineries in St. Croix; the Sahara Dust particles; mold and pollen all contribute to the frequent asthma exacerbations and hence hospitalizations. The MCH clinics continue to educate parents regarding the early signs of exacerbation and provide parents with a treatment plan that will assure that all children diagnosed with asthma receive management skills and knowledge to control the disease. Staff physicians and nurses continue to educate families on the importance of nutrition, healthy eating practices and habits, impact of both first and second-hand smoking, avoidance of environmental and household asthma triggers and other allergens, and appropriate management and treatment of early symptoms to avoid complications. Additionally, the MCH Program provides direct care for children with asthma and implements early treatment with pulse oximetry, nebulization and initial dose of steroids -- acts that have decrease the rate of hospitalizations. In 2009 51/10,000 were hospitalized but in 2011, 19.7/10,000 were hospitalized. Community outreach and education are important in the proper management of asthma and as such, the MCH staff has gone into the schools and Head Start Program to educate teachers and parents on recognizing the signs and symptoms of asthma and treatment protocols. Asthma remains a significant public health challenge in the territory and an area where methods to collect and analyze data more effectively is critical. It is generally recognized that children with asthma who are unable to gain access to primary care or prescription medications due to uninsured or underinsured status are at a greater risk of needing hospitalization. Therefore, appropriate asthma management in young children is a primary focus of this program with the ultimate goal of decreasing emergency room visits of young children for asthma related complaints, and to improve the lives of those who live with asthma.

The Title V program will continue to work closely in collaboration with the VI Chapter of the American Lung Association to create a better awareness of asthma; and to provide asthma education to health professionals, school personnel, and other key individuals who offer services to this population. Additionally, an Asthma Care protocol and plan of action for home and school based on NIH National Heart, Lung, and Blood Institute (NHLBI) and New York State Asthma Plan is being developed for implementation by the end of calendar year 2013.

The territory has been awarded monies through the Supplemental Environmental Program (SEP) to develop a Pediatric Environmental Health Center which will among other services, provide specialized services for children with asthma- Pulmonologists, Epidemiologist, surveillance team members and hence, will overall increase and improve services for children with asthma.

### Health System Capacity Indicator #02:

The percent Medicaid enrollees whose age is less than one year during the reporting year who receive at least one initial periodic screen.

The Early Periodic Screening, Diagnostic and Treatment (EPSDT) program provides well-child and comprehensive pediatric care for children and adolescents through age 20. Medicaid data systems in the territory lack the capability to provide specific data relating to periodic screening. This data is not available from the Medicaid program. Screening services are provided to all children accessing care at the MCH clinics. CPT and ICD-9 coding for these services was provided to MAP.

Paid claims documentation is unavailable from the MAP. The actual number of eligible children is unknown as the MAP data system does not provide this information.

The EPSDT periodicity schedule is used for all children receiving services at both MCH clinic sites. Estimated clinic sites data shows that 50 - 59% of children have Medical Assistance while 32- 42% are uninsured. Due to the stringent requirements for household income many families and children who are eligible for MAP by mainland standards are not certified in VI. The MCH Program supports delivery of preventive health services, such as health screenings and immunizations; refers uninsured infants and children seen in the clinics for determination of Medicaid eligibility; and encourages collaboration between Title V and the Medical Assistance Program to ensure that EPSDT services are provided to all eligible or certified children. Parent education on EPSDT services is not provided to families at the time of certification by the Medical Assistance Program. Therefore, the Title V program has undertaken to train staff both clinical and administrative to provide this information to parents who access the health care system through MCH clinics regarding the preventive and treatment services and supports that are available to them. The status of the MAP program's ability to report paid claims data remains unchanged. Data is not collected or reported from CMS Form 416.

Additionally, the implementation of the Bright Futures Model -- an evidence based, nationally approved age appropriate developmental screening tool for ages 0 -- 21 years provides additional screening beyond physical and gross developmental screening. It screens the home environment, the social and emotional stability of both the child and the family and provides excellent information for the parents regarding different developmental stages and age-appropriate issues.

All Hi-Risk infants regardless of whether they have Medicaid or not are screened using the Ages and Stages Questionnaire (ASQ) -- national developmental screening tool that is recommended by the American Academy of Pediatrics.

#### Health System Capacity Indicator #03:

The percent of CHIP enrollees whose age is less than one year who received at least one initial or periodic screen.

This HSCI is not applicable to the V.I. due to the Medicaid Cap. The Child Health Insurance Program, CHIP, is administered by the Bureau of Health Insurance and Medical Assistance. The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS as Congress did not approve adequate Child Health Insurance Program (CHIP) monies for the territories that would have allowed a regular Child Health Insurance Program.

Due to the limitations of the statutory cap and inadequate funding levels, VIDOH has been unable to address the health care needs of uninsured children. Limited S-CHIP funds are combined with MAP to provide health care for Medicaid eligible children. Service utilization or eligibility data is not available from the program.

#### Health Systems Capacity #9B:

The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Information.

The MCH & CSHCN Program has the ability to access data via written request for program planning or policy purposes. Linkages with electronic databases that house the data are not currently available. The MCH program has had long lasting issues with data collections and as such applied for the State System Development Initiative (SSDI) to assist with this issue. Funds for this grant will be utilized to implement a web-based system that will allow tracking for Newborn Genetic Screening and Newborn Hearing Screening. This system will interface with the hospital system and allow for easier access to data needed for many of the other Performance Measures that deal with low births, prenatal care and maternal risk factors. Accurate and timely data ensures implementation of programs and services that will increase better pregnancy and newborn outcomes.

MCH is also negotiating to replace the current database system (HealthPro) which is not web-based and limited in its reporting and tracking capabilities. It is anticipated that this new database system Well Family System (Go Beyond MCH), which is web-based and can be customized to provide data for the national and state performance measures and meet MCH goals.

The VI Dept of Health Institute Technology is currently working on up-grading their database system to provide linkage of data between the various Health Dept agencies -- it is anticipated that this system will be in place by 2013.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and 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, headed by the Director of MCH & CSHCN, is responsible for conducting the statewide assessment of needs, agency management, program planning and implementation, policy development, and interagency collaboration. Within the Administrative Unit are Program Administrators on each island who supervise the financial and clinic management, and program activities.

In FY '11, 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
- Subspecialty Care Services

Throughout FY'11, 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 the expanded V.I. Perinatal Inc., (Promoting Healthy Families-HCAP and Healthy Families, Healthy Babies Initiative).

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

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

### **B. State Priorities**

As a result of the discussion of the previous priorities identified in the 2005 needs assessment, the priorities identified by the stakeholders, and recommendations of areas to be considered when narrowing down the priorities, a consensus was reached that the new priorities needed to be more focused and measurable. It was agreed that the list of priorities identified by the stakeholders would provide guidance for ongoing MCH planning and implementation. Along these lines, ten new MCH priorities were set for the 2010- 2015 Need Assessment cycle 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.

Development of statewide priorities for the USVI followed the completion of the local needs

assessment, summarization of local priorities, analysis of statewide MCH health status, and the assessment of the MCH system capacity. The process was developed by MCH Administrative Unit and Continuous Quality Improvement (CQI) staff, and included staff meetings, self-assessment survey, and work group. The staff meeting provided a needs assessment status update, an orientation to the importance of priorities for the MCH Program, an introduction to needs assessment findings, and guidance on completing the survey. In preparation for completing the web survey, staff was provided with an update on the needs assessment surveillance data, USVI Title V Needs Assessment summary, and the 2005-2009 Title V priorities. The survey facilitated staff assessment of the leading priorities for capacity needs for the 2010-2014 period, and provided an opportunity for staff to write and submit priority statements for consideration.

Following the summarization of the staff survey, a work group reviewed the multiple data sources to identify leading overall priorities and begin to frame priority statements. The work group was composed of approximately 20 staff from throughout the MCH Program, approximately half of whom have been involved in the ongoing needs assessment steering committee. Therefore, the work group included individuals familiar with the details of the process as well as others who brought a fresh perspective to the selection of priorities. The selection of priority topics was facilitated through a mapping process by identifying key themes and the many interconnections between potential priority topics identified by LHJs, through statewide surveillance data, and by staff. This process facilitated the next step of framing the priority statements based on the leading priorities and the interconnections between them. Additionally, priority statements submitted by staff through the web survey were referenced throughout this process. Draft priority statements were developed by work group members and reviewed by senior MCH Program management.

After reviewing the data from the Needs Assessment and the data obtained from the various health clinics in the territory, as well as the information provided from discussions with MCH partners, the MCH CQI team prioritized the needs of the territory in the following manner and decided to allocate the resources to meet the needs according to the listed priorities. There are many needs in the territory but the adolescent population and the children with special health care needs are the most vulnerable populations in that they lack both adequate access to health care and adequate services to meet their needs.

Given the data obtained from the Needs Assessment about the adolescents in the territory of the Virgin Islands, and the fact that some of the teenagers reported that discussions about these various risky behaviors were helpful, the MCH CQI team was compelled to make Adolescent Health Care a priority by providing more services and more education -- ways to effectively impact the adolescents in the territory. But the services and education provided must also include parents especially since data from the needs assessment indicate that youth do not perceive their parents as setting rules or expectations with respect to drugs and alcohol, whereas schools do. With parental education, consistency across all settings in which a young person grows might be achieved and hence reduce some high-risk behavior, especially in view of the fact that adolescents are less likely to engage in activities/behaviors that are disapproved of by their parents.

The area of transition is still an area that requires more coordination and collaboration to ensure that these children continue to receive adequate and appropriate services once they transition into adulthood. In these difficult economic times, strengthening partnership to pool financial and personnel resources would be beneficial to the programs, the families and the children of the territory. Without good outreach and educational programs for the community and for the community based organizations that serve the various populations in the territory, there would be no standard of health care being administered. Of course it is imperative to continue to increase access to prenatal care and access to health care for all MCH populations and continue developmental screenings and evaluation, hence they continue to be on our priority list. Utilizing the tools and resources provided by GOT Transition Initiative, the MCH program will embark on restructuring the transition plan. the program has also requested TA in this area and with these

tools and it is the intention of the program to begin implementing a new plan in 2013.

The problem of obesity is a national problem and the territory cannot effectively be addressing this problem until enough data is collected. We can continue to promote healthy eating habits and exercise to help in the preventative area by using the WE CAN (Ways to Enhance Childhood Activity and Nutrition) program. The Needs Assessment gave us some insight into the adolescent obesity problem that exists, in that when the BMI data was analyzed, 32% of the 289 adolescents who responded to the surveys were overweight and 19% were obese. What is most concerning is the lack of awareness of body weight. Overweight respondents did not perceive themselves as overweight, despite high BMIs. Although 16.3% of respondents identified themselves as slightly to very underweight and 26.7% as slightly (22.5%) to very (4.2%) overweight, their BMI data suggested something very different. More than 12% of individuals had BMIs =97th %ile, 7% were between 95th to 97th%ile, and 13% between 85th to 95th%ile, meaning that 32% are overweight and 19% are obese. The most concerning are those 36 individuals who were clearly extremely overweight at =95th%ile, but only 10 out of the 36 identified themselves as very overweight. Interestingly, less than 1% of the 289 survey respondents did not define their weight category, but 12.8% of respondents did not give their weight or height. This may cause one to speculate that many of those respondents were in the >95th%ile group, meaning that the discordance between perception and reality is even greater than what was measured.

These findings are not unlike data generated from other studies done in the US mainland and in other European countries. Because of the risk factors of obesity (Hypertension, Diabetes, High Cholesterol and Cardiac Disease) the continued promotion of healthy lifestyles is a definite priority. Data collection has been a significant issue and requires great collaborative efforts on the part of many agencies. The significance of data collection beyond the MCH clinics and other clinics is well known to the MCH CQI team particularly in regards to our efforts to create policies and procedures and seek additional funding sources. Data collection and collaboration require strengthening partnership and re-evaluating the current system collection and analysis. In an attempt to develop our infrastructure and our linkage, the program applied for the State System Development Initiative Grant (SSDI) and was awarded \$65,357.00 to develop a strategy and system of data collection and analysis by strengthening and developing partnership as well as implementing a database system.

The Virgin Islands MCH & CSHCN has identified the following top ten (10) 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.

- To increase services to adolescents and young adults in all areas of primary and preventive care appropriate using a positive healthy youth development model.
- To increase the percent of CSHCN families' participation in transition planning to at least 50%.
- To improve and strengthen linkage of special needs children with needed health and community-based support services.
- Provide technical assistance, education, training materials and programs for community-based family support organizations that serve the maternal and child population.
- To promote community partnerships.
- To improve access to prenatal care for medically underserved women and increase healthy birth outcomes; promote reproductive health services.
- To improve access to primary and preventive health care services for all segments of the MCH population.
- Ensure access to developmental screenings and evaluations for children that are identified as high-risk.
- Promote healthy lifestyle practices and reduce the rate of overweight children and adolescents through implementation of the CDC-WE CAN (Ways to Enhance Child Activity & Nutrition) Program.

- Enhance efforts to improve data collection and collaboration.

### C. National Performance Measures

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

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	100	95	95	95	95
Annual Indicator	86.7	40.3	70.0	82.5	53.1
Numerator	130	81	70	160	85
Denominator	150	201	100	194	160
Data Source		NBS Program	NBS Program	NBS Program	NBS Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	95	95	95	98	98

#### Notes - 2011

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

Numerator for 2011 reflects rescreening, final diagnosis, counseling and/ or enrollment in appropriate treatment for identified disorder.  
All presumptive or initial positives are confirmed by DNA analysis.

All data obtained from the Newborn Screening Database

#### Notes - 2010

Denominator for 2010 reflect s initial positives for for expanded screening - total 48 disorders. This includes G6PD- 62; Sickle cell disease -7; Sickle cell trait - FAS -92 / FAC-28 and FAV-5.

Numerator for 2010 reflects rescreening, final diagnosis, counseling and/ or enrollment in appropriate treatment for identified disorder.  
All presumptive or initial positives are confirmed by DNA analysis.

All data obtained from the Newborn Screening Database.

#### Notes - 2009

Denominator for 2009 reflects initial positives for expanded screening - total 48 disorders.

Numerator for 2009 reflects rescreening, final diagnosis, counseling and/ or enrollment in appropriate treatment for identified disorder.

All data obtained from the Newborn Screening Database.

**a. Last Year's Accomplishments**

Initial newborn screening continued to be performed by both hospitals during fiscal year 2011. MCH & CSHCN continued to ensure timely follow-up of reported positive results, and comprehensive medical care and management care for all children identified through screening with an inheritable disorder.

A decrease in hospitalizations and complications in children diagnosed with sickle cell disease continues. Hospitalizations are reported by parents and discharge summaries, and hence accurate data is not always available. However, prevention of morbidity and mortality due to early identification, treatment and management continued to be successful and there were no deaths reported due to complications during this fiscal year. One hundred percent of newborns confirmed with sickle cell disease were entered into a comprehensive system of care which included an initial pediatric hematology evaluation by four months of age with continued follow-up by both the Pediatrician and Hematologist. Dr. Condon Richardson, a local pediatric hematologist based at the Charlotte Kimelman Cancer Center on St. Thomas or off-island Pediatric Hematologist in Puerto Rico provided their follow-up and management.

The increased number of children with complicated sickle cell disease, which requires the use of Hydrea, must be closely monitored for side effects or compliance issues

To date for the fiscal year four (4) infants were diagnosed with sickle cell or other hemoglobin variant disease. 100% are enrolled in comprehensive care and receive prophylactic penicillin and Folic Acid.

Parents and families of newborns identified with sickle cell trait continue to receive trait counseling. Their families receive on-going education and counseling on sickle cell disease management.

The number of children with G6PD deficiency continues to increase and counseling and education is also provided to the families in a timely manner. Since there is no treatment for this disorder, children are generally monitored for any complications that may occur secondary to exposure to toxins that will cause a severe anemia.

The program had some challenges this past fiscal year with the forced early retirement and layoffs of key personnel responsible for monitoring the genetics program thus leaving gaps in service. Nevertheless, the nursing staff and Physicians have taken on the responsibility of gathering the reports and identifying the abnormal labs in addition to their usual role of providing counseling and education to families with newborns having abnormal results.

The other challenge that the program faced in providing timely contact with the families of newborns who had abnormal results was in obtaining accurate demographic information.

Discussions with the Nursery staff in obtaining more detailed demographics to ensure proper follow-up were held this past fiscal year.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Achieve 99% initial screening of infants for selected genetic/metabolic disorders	X	X	X	
2. Follow-up and track infants with unsatisfactory or abnormal results.	X	X		
3. Refer all children with a diagnosed metabolic/genetic disorder for appropriate follow-up and treatment.	X	X		
4. Refer all children identified with significant hemoglobinopathy	X	X		

for Pediatric Hematology evaluation and diagnosis by 4 months of age.				
5. Utilization of an integrated newborn genetic-metabolic and hearing screening database for tracking and surveillance		X	X	X
6. Continue to work towards development of data linkage of newborn screening records and birth certificates.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Follow-up testing is provided for all abnormal and/or unsatisfactory results to assure completion of screening.

Patients and families with positive results have been receiving access to genetic counseling, case management and comprehensive care. Sub-specialty consultation with a board-certified Pediatric Hematologist will continue to be available. Parent support group activities on each island is continuing.

Negotiations for a contract to provide an integrated newborn metabolic/genetic/hearing tracking and surveillance database are in process which will provide useful information for statistical reporting and tracking.

The program is working towards maintaining the 100% follow-up rate for entry into comprehensive medical care for children diagnosed with sickle cell disease or other metabolic disorders.

Public health nurses continue to follow-up this special needs population by provision of case management and care coordination services.

The SSDI coordinator will be also be assigned to assist with the input of the data into the genetic database system and coordinate with the nurses and physicians to identify abnormal results.

With the completion of the contract to obtain the OZ System Database utilizing SSDI funds, MCH will be able to more efficiently and effectively obtain and track the results of the metabolic screening.

**c. Plan for the Coming Year**

The MCH program will continue to provide timely follow-up with genetic counseling and education for all newborns with abnormal genetic results. The newborns and their families will be provided access to comprehensive medical care and management. The integrated newborn metabolic/genetic/hearing tracking and surveillance database will provide useful information for statistical reporting and tracking. The program will continue to support the efforts of Parent Support groups for Sickle Cell Disease. The program anticipates that the 100% follow-up rate for entry into comprehensive medical care for children diagnosed with sickle cell disease or other metabolic disorder will be maintained.

**Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated**

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	1784			
<b>Reporting Year:</b>	2011			
<b>Type of Screening</b>	<b>(A) Receiving</b>	<b>(B) No. of Presumptive</b>	<b>(C) No. Confirmed Cases</b>	<b>(D) Needing</b>

Tests:	at least one Screen (1)		Positive Screens	(2)	Treatment that Received Treatment (3)	
	No.	%			No.	No.
Phenylketonuria (Classical)	1513	84.8	0	0	0	
Congenital Hypothyroidism (Classical)	1513	84.8	15	0	0	
Galactosemia (Classical)	1513	84.8	0	0	0	
Sickle Cell Disease	1513	84.8	4	4	4	100.0
Biotinidase Deficiency	1513	84.8	14	0	0	
Cystic Fibrosis	1513	84.8	2	0	0	
G6PD Deficiency	1513	84.8	81	81	25	30.9
Head Start Hearing Screening	836		0	0	0	
Gonorrhea	1756		93	0	0	
HIV	1634		146	0	0	

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	30	30	40	40	40
Annual Indicator	20.0	12.2	4.7	41.8	32.0
Numerator	250	187	70	403	351
Denominator	1248	1530	1505	965	1098
Data Source		HealthPro/MCH	Client Satisfaction Survey	Client Satisfaction Survey	Client Satisfaction Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2012	2013	2014	2015	2016
Annual Performance Objective	40	45	50	50	50

**Notes - 2011**

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

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

**Notes - 2010**

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

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

**Notes - 2009**

Numerator based responses to client satisfaction survey during March-April 2010 in St. Thomas-St. John District.

**a. Last Year's Accomplishments**

The program continued to focus most of the personnel time and other resources toward provision of direct health care services to children and their families, particularly, children with special health care needs; and as such the parents directly participated in the decision-making process along with the physicians and nurses and helped to create a plan of action that provided the necessary services for their children with special health care needs.

Several of these families have participated in advocating for services for their children after participating in some of the Dept of Human Services advocacy training programs. During this fiscal year, the Dept of Human Services sponsored training workshops for providers to learn how to educate their clients in advocacy - some of the MCH staff participated in these trainings.

The program continued to work closely with the Infants and Toddlers Program to ensure enrollment in early intervention services and coordination of care.

The program continued to partner with 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.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuation and strengthening of existing linkages and referral network		X		X
2. Encourage family representation at the annual AMCHP meeting.		X		X
3. Program staff assists families with identifying needed resources		X		
4. Develop and administer exit surveys to determine satisfaction after clinic visits		X	X	X
5. Develop and administer annual family satisfaction surveys		X	X	X

6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Virgin Islands Title V Program plans to address this measure through continuation and strengthening of existing linkages and referral network.

Other strategies to be employed are: expand outreach efforts and to support culturally diverse populations, providers and community organizations; 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.

Activities to develop and implement an action plan to enhance services for families of children with special needs including training for parents and families will be achieved based on available financial resources.

The program continues to develop and administer annual family satisfaction surveys. These are available in English and Spanish. Other actions to achieve this goal are to continue coordination with Child Find activities in Part C-IDEA Program, Department of Education-Special Education, Pre-School Education & Head Start Programs, and encourage participation through culturally sensitive and appropriate family training and education.

**c. Plan for the Coming Year**

The Virgin Islands Title V Program plans to continue to strengthen existing linkages and referral network. and create new network linkages to provide additional support for families with children with special needs.

The program will continue to expand its outreach efforts that were begun this year and continue to support culturally diverse populations, providers and community organizations; identify barriers that prevent families from accessing health care on a regular basis; encourage family-professional partnerships in all program activities, and encourage and promote participation in parent mentor/support groups to families, family advocacy organizations and providers as stated above.

The program plans to collaborate with its partner, VI Family Information Network on Disabilities (VIFIND), to provide the additional training needed for staff, families and providers towards the achievement of this goal. VIFIND is a community based advocacy agency teaches parents about their rights under the Americans with Disabilities Act, IDEA and Section 504 of the Rehabilitation Act, and empowers them to actively participate in decisions affecting their child with special needs. Parents are assisted to locate information, resources, programs and services, and to communicate effectively with professionals and services providers.

Families will be asked to participate in the pilot survey for one part of the obesity project and to participate in giving suggestions about methods to implement the WE CAN (Ways to Enhance Childhood Activity and Nutrition) program that will be effective in meeting the needs of our population.

Continue program staff participation in family support and advocacy organizations.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	50	50	55	60	60
Annual Indicator	38.1	54.6	39.9	45.0	30.0
Numerator	475	835	600	434	329
Denominator	1248	1530	1505	965	1098
Data Source		HealthPro/MCH	MCH Program	MCH Program	Health Pro Database System/MCH
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	60	60	65	65	65

**Notes - 2011**

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

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

Denominator obtained from MCH clinics monthly reports.

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

**Notes - 2010**

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

Numerator obtained from 2010 needs assessment responses to questions related to care coordination and satisfaction with services.

**Notes - 2009**

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

These services meet the American Academy of Pediatrics defines the medical home as “a

model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Denominator obtained from MCH clinics monthly reports.

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

**a. Last Year's Accomplishments**

The definition of "Medical Home" as it's applied on the US mainland has a different meaning in the territory. The Title V program is considered the medical home as defined by the American Academy of Pediatrics, for a large percent of the CSHCN population. For many families, the medical home is where a child with special health care needs and his or her family can count on having medical care coordinated usually by a public health nurse or service coordinator, with the involvement of the pediatrician. These nurses and families work together and access all of the medical and non-medical services needed to help CSHCN achieve their potential. Factors that contribute to this are increasing numbers of underinsured and uninsured families; welfare to work policies for single head of household families that offer low paying jobs with little or no medical insurance benefits or paid days off; and an overall poverty rate of 43.6% for children under 18 years in the territory in single parent homes. Additionally, private pediatricians and other primary care providers within the territory routinely refer families to the program for access to specialty care that is not otherwise available within the territory.

The 330 funded health centers now have a full time Pediatrician and 2 Family Practioners, but they still refer the children with special health care need to the MCH clinics because of lack of coordinated health care services for this population. This places severe limitations on their ability to provide medical homes.

VIUCEDD (Virgin Islands University Center for Excellence in Developmental Disabilities) had sponsored a Parent to Parent program in which parents are trained to help other parents navigate the system and oobtain the services that are needed for their children.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage families of CSHCN to access comprehensive care through a medical home.				X
2. All primary and specialty care is coordinated by public health nurses in the Title V program.	X	X		
3. Educate families of children with special health care needs of the importance of medical home		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Families with private or group insurance may opt to remain with a private provider for primary care and access Title V services for specialty or sub-specialty care only.

The program authorizes medical, laboratory and diagnostic care, and other treatment services including rehabilitative services, for children who are uninsured or families are determined to have the inability to otherwise pay for services.

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.

**c. Plan for the Coming Year**

Existing partnerships such as those with the non-profit 330 FQHC's, private pediatricians and the Part C-IDEA Program will be utilized to plan, develop and implement an on-going training program to enhance the quality and comprehensiveness of care in order to move towards creating medical homes for children with special health care needs.

Develop a plan to promote the medical home approach through collaborations with community based organizations and professionals, i.e. child care providers, that will assure their assistance in encouraging families to access the comprehensive and coordination available in a medical home.

Reconvene the medical home task force to implement a plan to promote the medical home approach.

Parents are encouraged within their financial confines to establish a relationship with a private pediatrician.

Establish data collection mechanism to monitor, track and determine positive outcomes and successful achievement of HP 2020 Objective 30.2 - Increase the proportion of children with special health care needs who have access to a medical home (Baseline: 20.4% of children aged 0-11 with special health care needs in 2005-2006, target: 22.4%; and Baseline:13.8% of children aged 12 through 17 with special health care needs in 2005-2006, Target 15.2%)

Promote the use of the Bright Futures Model, which is a tool and a best practice for increasing quality of health care and health education for children and families. This will assist the program in furthering the goals of the MCH Priorities.

Partner with other agencies such as VI FIND ( Virgin Island Family Information Network on Disabilities to help the MCH families navigate the system and become trained to train other parents to be advocates.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	35	35	35	35	50
Annual Indicator	25.0	52.0	8.3	65.0	50.0
Numerator	312	795	125	627	549
Denominator	1248	1530	1505	965	1098
Data Source		HealthPro	MCH Program	MCH 2010 NA	HealthPro database/MCH
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	50	60	60	65	65

**Notes - 2011**

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

Denominator obtained from MCH clinics monthly reports of CSHCN.

**Notes - 2010**

Numerator reflects # of respondents who have insurance coverage public or private for their special needs child and are satisfied.

Data obtained from 2010 needs assessment.

**Notes - 2009**

Numerator obtained from MCH clinics in both districts reflects families reporting a source of insurance other than Medicaid.

Denominator obtained from MCH clinics monthly reports.

52% of families accessing care at MCH Program report no source of insurance.

**a. Last Year's Accomplishments**

This measure is not directly applicable to the territory. There is a Medicaid cap that places severe limitations on the ability to provide insurance for eligible families. SCHIP funds are utilized to pay unpaid medical expenses for children with Medicaid.

There are no HMO's, MCO'S or PPO's providing Medicaid managed care coverage.

Some private sector employers provide medical benefits for their employees with no family coverage options.

The population known to be below the federal poverty level is presumed eligible for Medical Assistance. However, 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 preventive or primary care. 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. Families of children with special needs who have insurance through MAP have limited ability under program requirements to access care at private providers which restricts their choices of providers. Children with special health care needs usually require a higher and more comprehensive level of health care beyond that required by normal children and are more likely to experience catastrophic illnesses. These populations of children and families generally have extremely low incomes and are more likely to be uninsured. Children with health insurance are likely to obtain adequate health care therefore insurance coverage and the type and extent of coverage is an important indicator of access to care. Children who are under/uninsured usually have more emergency room visits and hospitalizations, and time lost from school. Adequate insurance allows access to comprehensive care, which in turn reduces emergency room visits, hospitalizations, and time lost from school or work.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Title V program provides access to specialty and sub-specialty services	X	X		X
2. All children in the territory have access to these services regardless of source of payment or ability to pay for services.		X		
3. Refer all families without insurance to Medical Assistance program to determine eligibility.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The MCH program continues to provide comprehensive health care services for individuals with Medicaid and for those who are uninsured and underinsured within the territory, especially to families with children with special health care needs at a low, affordable cost. A sliding fee scale is available for clinic services. Income eligibility is based on 250% of the federal poverty income guidelines.

The Government of the Virgin Islands requires all of its employees to be covered by group medical insurance. The current carrier, CIGNA, is considered a PPO with most local providers a part of the network.

Families without health insurance are less likely to have a regular source of care and access the health care system only when necessary in order to avoid out-of-pocket costs.

The Title V program provides 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.

With the new health care reform initiatives, the VI Medicaid program may be in a position to provide more services to individuals secondary to the lifting of the Medicaid cap for the VI.

**c. Plan for the Coming Year**

The program will continue to provide access to sub-specialty services for children with special health care needs utilizing pediatric sub-specialists. All children in the territory have access to these services regardless of source of payment or ability to pay for services. Off-island referrals are primarily for diagnostic services such as cardiac catheterization, cardiac sonography, brainstem audio-evoked response testing, and less frequently, oncology, endocrinology, gastro-enterology and neuro-psychology services that are not available on-island for the pediatric population. The program will continue to support the parents in advocating for better insurance coverage to increase access to comprehensive health care services.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	30	30	35	35	40

Annual Indicator	14.8	0.0	0.0	28.9	20.0
Numerator	185	0	0	279	220
Denominator	1248	1530	1505	965	1098
Data Source		MCH Program	MCH Program	MCH 2010 NA	MCH Program/CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	40	40	40	40	40

**Notes - 2011**

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

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

**Notes - 2009**

Information for this measure was not collected.

Questions related to this measure were included in the 2010 Needs Assessment.

**a. Last Year's Accomplishments**

Efforts to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children requiring services receive them continued. The program provided information and referral services to appropriate agencies based on families identified needs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Families are referred to appropriate community service agencies or organizations		X		
2. Maintain and periodically update as needed a resource directory of all community-based services and organizations	X	X		X
3. Continue to assist families in accessing services based on identified needs		X		
4. Develop and implement a referral / feedback system for tracking purposes.		X		X
5. Develop guidelines for minimum standards of service system of care development				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The program continues partner with other agencies and community-based organizations to ensure that the needs of families and children with special health care needs are met. The program also continues to provide information and referral services to create a comprehensive system of health care for this population that is easy to access and meets their specific needs.

**c. Plan for the Coming Year**

Build on existing collaborative partnerships with community based organizations that provide services to children and families. These include, but are not limited to, advocacy groups, legal services, resource and training centers, child care providers, family support and faith based organizations.

Provide technical assistance and consultation for community-based organizations that serve our maternal and child population.

Provide education, training materials and programs for community and community organizations that serve both mothers and children in the territory.

Continue to assist families in accessing services based on identified needs.

Develop and implement a single point of referral for service coordination across agencies to maximize usage of resources for services.

Utilize a referral / feedback system for tracking purposes and to determine outcomes of services provided.

Continue efforts to implement family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families.

Periodically evaluate referral system to assure that it is consistent with the Title V vision to integrate and strengthen community-based programs into a system of services that is more accessible and responsive to families and communities.

Early Childhood Advisory Council (ECAC) Health and Wellness work group will look at partnering with MCH to implement a unified referral form for all community services to include that will allow participants to grant consent for information sharing among selected services agencies.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	30	35	20	20	10
Annual Indicator	1.2	0.7	0.3	6.7	2.6
Numerator	15	11	5	65	20
Denominator	1248	1530	1505	965	784
Data Source		MCH Program	MCH Program	MCH Program	MCH Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	15	20	20	20	20

**Notes - 2011**

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

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

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

**Notes - 2009**

Numerator reflects data provided by MCH Nursing in St. Thomas-St. John District.

**a. Last Year's Accomplishments**

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

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

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

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

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide transition information to families.	X	X		
2. Solicit and encourage family and adolescent participation in transition planning.		X		
3. Establish data collection mechanism to monitor and track successful and effective transition.		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Transition planning with families provided by public health nurses. The program continues to utilize transition planning checklists. The program increased collaboration to ensure that children will access established community based programs to smoothly transition from childhood to adulthood; and continue to increase collaborative efforts with the Community Health Adult Physicians to ensure that the medical needs of this population continue to be met.

**c. Plan for the Coming Year**

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 to participate in transition planning and provide age appropriate transition services.  
 Establish data collection mechanism to monitor and track successful and effective transition.  
 Provide technical assistance for the staff to get additional training on the developing and implementing a system of transition.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	70	70	70	75	75
Annual Indicator	80.0	31.2	60.5	57.0	80.6
Numerator	943	215	348	2581	482
Denominator	1179	690	575	4529	598
Data Source		MCH Program	MCH Program	VI Immunization Program	MCH Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	75	75	75	75	75

**Notes - 2011**

Denominator is # of children 19-35 months old born between January 2006 and July 2008.  
 Numerator is of # complete for age according to the National Immunization Survey for 2009. This reports reflects all children 19-35 months old in the territory whose immunization status is reported to the program.

The 2010 National Immunization Survey (NIS) reports a 43.7% immunization rate for the Virgin Islands. The estimates are based on children born January 2007 through July 2009. The

percentage reflects coverage for 4:3:1:3:3:1:4 vaccine series that includes the full Hib series. (4 DTap:3 Polio:1MMR:3 Full HIB: 3Hep B:1 Varicella:4PCV. The NIS reports 45.6% that is the series without the full HIB series. MCH data reflects the full HIB series.

**Notes - 2010**

Denominator is # of children 19-35 months old born between January 2006 and July 2008. Numerator is of # complete for age according to the National Immunization Survey for 2009. This reports reflects all children 19-35 months old in the territory whose immunization status is reported to the program.

**a. Last Year's Accomplishments**

Technical and contractual challenges and deficiencies with the Immunization Registry have not been resolved according to Immunization Program staff. Data required for this fiscal year's performance measure remains unavailable from the Immunization Program. The MCH program relied on the National Immunization Survey Results of 2010 since the 2011 Survey results are still not available.

MCH nurses and physicians ensure that infants and children receive age appropriate immunizations at well child visits, primary and preventive care visits. MCH staff continued to track the immunizations given within the clinics to assess the deficiencies in vaccine administration

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assessment of immunization status included in each primary and preventive care visit	X		X	
2. Continue WIC immunization linkage		X		X
3. Families are provided literature on AAP/CDC Guidelines on Immunizations	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Women, Infants and Children Nutrition Program (WIC) ensured that children participating in the program completed their immunization schedule through age 2. Participants who are not up to date with their immunization are referred to the Immunization Clinic as per a Memorandum of Understanding that VI WIC has with the immunization program according to policy and procedure 2.09.

Immunizations continue to be a vital part of every primary and preventive care visit at MCH clinics, the community health centers and other clinics.

MCH staff participated in training activities sponsored by the Immunization program.

Immunization Clinic continues to provide updates on vaccines and immunization schedules for the MCH staff on a regular basis.

**c. Plan for the Coming Year**

The Vaccine For Children Program's mandate which stipulates that uninsured or Medicaid eligible/certified children can qualify to receive vaccine through from the program will continue to be implemented.

The program will continue to strive for at least 95% of all children receiving services to have completed recommended immunizations by age 3 through continuous tracking of immunization status of every child seen within the clinic.

Immunizations with parental education will continue to be a vital part of every primary and preventive care visit at MCH clinics, the community health centers and other clinics.

MCH program will continue to assure access to vaccines that are required for child care and school entry, and maintain access to vaccines that are indicated in some high risk children.

In order for MCH & CSHCN clinical staff to keep up with ever changing immunization policies the program will promote attendance at training sessions and annual immunization conference.

The program will continue efforts to raise immunization rates through promotion of awareness by means of outreach activities, distribution of parent education materials, identification of children who are not up to date.

Continue WIC linkage.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	15	15	15	15	15
Annual Indicator	16.4	9.8	49.9	25.6	17.1
Numerator	60	36	183	35	72
Denominator	3667	3667	3667	1365	4213
Data Source		Vital Records	Prenatal Clinics	Prenatal Clinics	Hospital Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	15	15	15	15	15

**Notes - 2011**

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

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

**Notes - 2010**

Data for this measure is obtained from prenatal clinics at DOH Community Health Clinic, MCH-St. Croix District and FQHC's (2).

Denominator is # of prenatal patients for reporting year.

Numerator reflects # of 15 - 17 year olds in that population. Births in this population receiving care at birth from private providers is not included.

Data for this reporting year is not available from DOH Office for Health Statistics. All data reported is provisional pending availability of final territorial data.

**Notes - 2009**

Data on 15-17 year females is not reported as a separate category in the VI Community Survey. Denominator is an estimate provided by Health Statistics.

Numerator for this reporting year from Office for Vital Records & Statistics. This is provisional data pending final tabulation and report.

**a. Last Year's Accomplishments**

MCH Program Pediatrician and staff from the Family Planning Program provided education and information to adolescents on age appropriate topics such as delaying sexual activity; sexual coercion; abstinence; refusal skills; and appropriate protection against STDs and HIV/AIDS. Sessions were held at public schools, juvenile centers, faith based organizations, and summer camps. Family Planning conducted weekly adolescent clinics to provide adolescents with access to information on reproductive health, appropriate contraceptive methods and evaluation.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to engage adolescents through outreach activities that emphasize responsible decision making	X	X	X	
2. Provide access to comprehensive services, STD counseling and testing for adolescents	X		X	
3. Continue to partner with Family Planning and Schools to provide educational outreach		X		
4. Provide staff training in adolescent health issues		X		X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Family Planning programs continued efforts to decrease teen births by providing confidential counseling and contraceptive services.

FP program staff continues to support teen pregnancy prevention activities by engaging adolescents through outreach activities that emphasize responsible decision making; education related to STD prevention and provision of clinical services. Staff continues providing education and outreach for clients aged 15-17 on reproductive health topics such as abstinence, decision making skills, healthy relationships, male responsibility, parent-child communication, safer sex, sexual responsibility, teen pregnancy issues and sexually-transmitted infections within the clinics and through outreach programs.

**c. Plan for the Coming Year**

The Family Planning Program will continue to strive to increase awareness, especially to adolescents on choices and consequences as it relates to reproductive health. 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 through collaboration with the 330 FQHCs to provide an adolescent program that addresses the health issues of this population, thereby increasing access to healthcare for teens at high risk for unintended pregnancies and STD through the Implementation of Satellite Teen Clinics on St. Thomas and St. Croix.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	35	20	10	15	15
Annual Indicator	1.1	8.5	6.6	13.6	9.2
Numerator	87	606	471	993	600
Denominator	7866	7130	7130	7297	6557
Data Source		Dental Program	Dental Program	Dental Program	Dental Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	15	20	20	20	20

**Notes - 2011**

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

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

**Notes - 2010**

Data for this denominator obtained from the 2008 VI Community Survey by the Eastern Caribbean Center - University of the Virgin Islands.

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

**Notes - 2009**

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

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

**a. Last Year's Accomplishments**

Dental services were available at clinics administered by the Department of Health. Services include: examinations, fluoride applications, fillings and extractions. The Medical Assistance Program (MAP) does not cover this service for enrolled children.

It is not anticipated that the Medicaid Program will have the resources to cover this service for VI children. Dental clinics continued to provide other oral health services, including assessment, oral examination, fluoride applications, restorative fillings and extractions.

The Medical Assistance program does not collect or report this data.

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.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote use of protective sealants			X	
2. Collaborate with WIC Program and the FQHCs that provide Dental Health Services to promote early start of good oral health practices.		X		X
3. Partnership established with territorial pediatric dentist to provide increased access to dental services	X	X		
4. Screening and assessments for other dental conditions, preventive dental care and referral as appropriate within the clinics and in Head Start Programs	X		X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

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. Dental clinics were closed this year due to layoffs of dentists and therefore there was a significant gap in providing valuable services to the children in the territory. The 330 FQHC center in St. Thomas recently hired a Dentist that is now providing dental services to the children and families who have Medicaid and who are underinsured or uninsured. The 330 FQHC in St. Croix continues to provide dental services to the children in St. Croix. Referrals to the only Pediatric Dentist on the island who also provides care to Medicaid patients continue to provide 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.

**c. Plan for the Coming Year**

The water supply in the Virgin Islands is not fluoridated. The use of sealants and fluoride supplements has been proven to reduce or eliminate decay in the permanent teeth of children. Partnership established with the pediatric dentist at the FQHCs to assist the program in providing the spectrum of oral health services especially to the CSHCN population will be continued. This partnership is anticipated to address community needs related to oral health and provide education to students, families, child care providers and other professionals related to maintaining healthy teeth, prevention of tooth decay and proper nutrition.

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

Promote prevention activities related to oral health education targeting the general public in collaboration with the Division of Dental Services.

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

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

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	2	2	2	1	1
Annual Indicator	11.6	4.4	4.5	0.0	9.8
Numerator	3	1	1	0	2
Denominator	25805	22697	22458	21628	20416
Data Source		OHS	VICS / OHS	VICS / OHS	VICS/OHS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Provisional	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1	1	1	1	1

**Notes - 2011**

Denominator: Data is from the 2009 VI Community Survey of individuals ages 0 -14 years of age.

Numerator: Data for this reporting year is from VI Office of Highway Safety 2011 statistics.

**Notes - 2010**

Data for this reporting year is obtained from Office for Highway Safety. No deaths in this age group were reported.

Denominator obtained from the 2008 VI Community Survey.

**Notes - 2009**

Denominator obtained from 2007 VI Community Survey, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from the Office for Highway Safety, 2009 Traffic Data Report.

**a. Last Year's Accomplishments**

VI Office for Highway Safety has engaged in an extensive territorial seat belt use campaign that has been effective in reducing the deaths of children within the territory secondary to Motor Vehicle Accidents. The Office of Highway Safety participated in Public Health Week and did presentations to the clients of MCH program regarding proper seat belt use. DVDs that educate in proper seat belt use and safety are regularly played during clinic hours to promote education to the families that utilize MCH clinics. Additionally, the Emergency Medical Services training staff provided injury prevention, infant and child safety, traffic safety including bike, skating, and motor vehicle passenger safety education to students, school staff, community organizations and other providers throughout the year. In addition, first responder and basic cardio-pulmonary resuscitation training were offered.

The Office of Highway Safety (VIOHS) had an on-going media campaign regarding substance use (alcohol and other drugs) and driving.

VIOHS strategies to reduce crashes, injuries and deaths included activities in reducing alcohol related deaths, increasing safety seat belt usage, proper use of child restraint seats, and reducing pedestrian deaths.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with VI-EMS and Office of Highway Safety (VIOHS) to promote injury prevention and traffic safety activities in the community			X	X
2. Continue to raise awareness on the importance of seat belt use and child passenger restraint seats via brochures/pamphlets/DVDs on seat safety and proper restraint measures			X	
3. Increase public awareness activities to include alcohol and other substance abuse safety issues as related to motor vehicle use			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The program will continue to partner with VI-EMS and Office of Highway Safety (VIOHS) to promote injury prevention and traffic safety activities in the community.

Continue to raise awareness on the importance of seat belt use and child passenger restraint seats through presentations, outreach fairs and child safety seat clinics.

Increase public awareness activities to include alcohol and other substance abuse safety issues as related to motor vehicle use.

**c. Plan for the Coming Year**

The program will support the efforts of the VI-EMS and Office of Highway Safety (VIOHS) to promote injury prevention and traffic safety activities in the community.

The program will continue public awareness through health fairs and within the clinics.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	50	45	45	50	50
Annual Indicator	43.8	30.3	3.0	29.9	28.2
Numerator	775	558	52	491	501
Denominator	1771	1844	1755	1642	1779
Data Source		WIC/PedNSS	WIC/NBS Database	WIC/NBS Database	WIC/Hospital Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	50	50	50	50	50

**Notes - 2011**

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

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

**Notes - 2010**

Data on exclusive breastfeeding is not available from the WIC Program for this reporting year.

**a. Last Year's Accomplishments**

The Virgin Islands WIC Program continued all efforts to actively promote, support and protect breastfeeding within the territory. VI WIC continued to remain the 'beacon of light' for breastfeeding promotion within the islands, as the only organization, which consistently promotes and supports breastfeeding within the territory.

The WIC program provided breastfeeding information to all prenatal clients at certification as well as individualized assistance to breastfeeding moms with problems.

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

WIC participated in the Pediatric Nutrition Surveillance System (PedNSS). Among the infants enrolled in the WIC program, 44% (501/1125) still breastfed at 6 months and 4% exclusively breastfed at 6 months as per the PedNSS.

The Virgin Islands Perinatal Inc, (VIPI) program is a program that works with pregnant females and has been providing education and promoting breastfeeding. For FY 2011, to encourage Breast feeding they bought several of their clients breast pumps. The WIC program sponsors the "La Leche" program which is a hospital based program that promotes breastfeeding to new mothers and educates on proper breastfeeding techniques.

All the prenatal clinics in the FQHCs continue to promote breastfeeding.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants	X	X	X	
2. Continue to promote the benefits of breastfeeding through educational pamphlets, DVD's and counseling		X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

To ensure that the WIC Program continues to promote, support and protect breastfeeding among WIC participants.

Continue efforts to ensure mothers that breast milk alone is sustainable to babies for up to six months. WIC will also continue to provide support for breastfeeding mothers who work. Moms are continually encouraged to breastfeed and are very comfortable breastfeeding in WIC clinic settings.

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

**c. Plan for the Coming Year**

Increase breastfeeding among new mothers by providing direct support and counseling in both WIC and MCH Clinics.

Maintain breastfeeding rates among new mothers by providing direct support and counseling in both WIC and MCH Clinics.

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

To promote, protect and support breastfeeding among WIC mothers.

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

To implement the WIC Breastfeeding Peer Counselor Initiative.

To procure breast pumps and other breastfeeding aides for use in WIC clinics.  
 Provide WIC clients with adequate nutrition education to make informed, lifestyle change decisions, using effective nutrition education interventions.  
 Provide breastfeeding information and aides to breastfeeding moms so that they may have a successful breastfeeding experience.  
 Provide counseling, support and assistance to WIC moms with breastfeeding problems.  
 The Title V program will continue to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants. This includes referrals for care from WIC to the MCH program and from MCH to WIC. Public health nurses will use opportunities to promote and support breastfeeding.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	96	90	90	95	95
Annual Indicator	79.3	92.7	91.5	90.0	85.4
Numerator	1405	1709	1606	1477	1519
Denominator	1771	1844	1755	1642	1779
Data Source		NBS Program	NBS Program	NBS	NBS Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	95	95	95	95	95

**Notes - 2011**

Data for this reporting year obtained from NBS Program based on # live birth admissions data received from both hospitals and # screened before discharge.

This information presented does not include the # screened post-discharge on an outpatient basis. An estimated 51% were screened within 2 weeks post discharge (135 of 260). Of the remaining 125 newborns, 85% were screened before 3 months of age (106 of 125). The remainder were considered lost to follow-up after numerous attempts to contact parents were unsuccessful.

**Notes - 2010**

Data for this reporting year obtained from NBS Program based on # live birth admissions and # screened before discharge.

This does not include # screened post-discharge on an outpatient basis. An estimated 50% were screened within 2 weeks post discharge (82 of 165). Of the remaining 83 newborns, 80% were screened before 3 months of age (66 of 83). The remainder were considered lost to follow-up after numerous attempts to contact parents were unsuccessful.

**Notes - 2009**

Numerator reflects screening during birth admission. Infants missed received outpatient screening.

Denominator reflects number of live birth admissions.

**a. Last Year's Accomplishments**

The integrated newborn screening database was modified and updated to provide reports. The database currently provides data on birth admission, follow-up outpatient screening and audiological diagnostic reports. However, challenges remain with generating integrated reports necessary for follow-up and tracking of infants referred for additional screening or audiological evaluation.

85% (1519 of 1779) of newborns were screened in calendar year 2011.

29 were referred for additional screening and audiological evaluation and diagnosis. One was identified with hearing loss and was immediately referred to Part C (Infants and Toddlers Program) for Early Intervention Services.

Increased communication between the Nursery and MCH -- results of hearing screen being placed on the newborn discharge summary and on the It's a boy/ It's a girl card has been effective in catching newborns that initially failed a hearing screen and need to be re-tested earlier during 2 week postnatal visit rather than later when they demonstrate language problems. Those that do not pass on repeat testing are immediately referred to Audiologist or ENT for full evaluation.

The program is funded 100% by the Title V Program.

Updated OAE testing equipment was received on both islands. This increased the ability for more precise and accurate testing results

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide otoacoustic emissions screening for all newborns before hospital discharge or by one month of age	X		X	
2. Provide hearing screening technicians on a daily basis	X		X	
3. Provide parent education literature on hearing screening.		X	X	
4. Increase awareness about the benefits of newborn hearing screening and early identification of hearing loss			X	X
5. Implement and maintain integrated database into one system for data collection, tracking, reports and analysis				X
6. Evaluate qualitative screening data to determine program efficiency in screening, identification of hearing loss and referral to early intervention services				X
7. Ensure enrollment into early intervention services for newborns diagnosed with a hearing loss by 3 months of age			X	
8.				
9.				
10.				

**b. Current Activities**

Training and evaluation for the screening technicians is on-going. On-site evaluations are done quarterly by the Territorial Audiologist to assess screening proficiency, communication / interaction with families; compliance with confidentiality rules and equipment care.

The MCH program was awarded the Newborn Hearing Grant and will be able to enhance screening efforts and implement an integrated Web based system that incorporates the genetic results with the hearing results upon discharge from the hospital. The implementation of this

system will enhance tracking of newborns.

The program is continuing to monitor and track infants identified with permanent hearing loss or impairment or have documented risk conditions for late onset of hearing loss.

MCH is promoting increased communication with the Nurseries by having the results of hearing screen being placed on the newborn discharge summary and on the It's a boy/ It's a girl card, which has been effective in identifying newborns who initially did not pass hearing screen and were able to be re-tested earlier during 2 week postnatal visit rather than later when they demonstrate language problems. Those that did not pass on repeat testing are immediately referred to the Audiologist for further testing and to ENT for full evaluation.

The territory has formed an Improving Hearing Screening and Intervention System (IHSIS) Team as part of a learning collaborative of the National Initiative for Children's Healthcare Quality (NICHQ).

**c. Plan for the Coming Year**

Newborn hearing screening will continue at both hospitals.

Additional Newborn Hearing Screening Technicians will be hired to provide assistance with follow-up for infants who need rescreening or referrals for audiological assessments using Newborn Hearing Grant funds.

Audiologists will provide follow-up for infants at-risk for late onset hearing loss.

Families of newborns identified with a hearing loss will be contacted by program staff to ensure follow-up and enrollment into early intervention by 6 months of age. The program will develop and implement referral and reporting mechanism to ensure enrollment into early intervention for each newborn diagnosed with a hearing loss.

Challenges still exist with gathering timely follow up data on infants referred for further diagnostic evaluation which should be minimized with the implementation of the tracking system.

MCH Program will continue improving data quality, collection, tracking and reporting procedures by implementing the new database system.

Updated screening equipment will be purchased with the funding received through the Newborn Hearing Grant.

Newborn hearing screening/follow-up rates will continue to be monitored on a monthly basis.

The program will embark on increasing awareness about the benefits of newborn hearing screening and early identification of hearing loss.

Through the NICHQ learning collaborative, the IHSIS team will develop a territorial newborn hearing screening and follow-up plan to detect infants with hearing loss early and improve the quality of care to newborns with hearing loss by:

- 1)Enhancing state performance of meeting EHDl program goals of screening, diagnosis, and intervention by 1, 3, and 6 months, respectively;
- 2)Building the capacity of state EHDl programs to use and apply quality improvement techniques to their work; and
- 3)Improving state data collection processes and tracking.

**Performance Measure 13: *Percent of children without health insurance.***

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	15	10	10	10	10
Annual Indicator	8.8	12.0	9.4	11.0	12.9
Numerator	2283	2728	2872	3308	3646
Denominator	25805	22697	30596	30079	28352
Data Source		VICS/ HealthPro	VICS / MCH clinics	VICS/MCH Clinics	KIDS Count/VICS

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	10	10	10	10	10

**Notes - 2011**

Denominator obtained from 2009 VI Community Survey for children ages 0 -18 years of age.

Numerator reflects the number of children ages 0 - 18 years of age reported by 2009 KIDS Count Data for the VI that have no insurance .

The Medical Assistance Program currently has no system in place to collect or report this data to CMS.

**Notes - 2010**

Denominator obtained from 2008 VI Community survey.

Numerator reflects number of children accessing services at MCH clinics in both districts with no source of insurance.

The Medical Assistance Program has no system in place to collect or report this data to CMS.

**Notes - 2009**

Denominator obtained from 2007 VI Community survey.

Numerator reflects number of children accessing services at MCH clinics in both districts with no source of insurance.

The Medical Assistance Program is not required to collect or report this data to CMS.

**a. Last Year's Accomplishments**

Children with Special Health Care Needs are disproportionately low-income, and because of this, they are at greater risk for being uninsured. Moreover, their needs for health care are greater.

MCH and CSHCN Programs refer families to MAP for eligibility determination.

There is no formal outreach program for the MAP or SCHIP Programs, since there are such limited resources to offer the families.

50% of children accessing care at MCH clinics were Medicaid certified. 42% were uninsured. 8% had private or group insurance.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Refer all families without health insurance to the Medical Assistance Program to determine eligibility	X	X		
2. All children registered in the Title V program receive services regardless of insurance availability or ability to pay	X	X		
3. Uninsured and underinsured children will continue to be provided financial assistance for access to diagnostic, specialty and sub-specialty care.	X	X		
4.				

5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Families determined to be eligible for the Medical Assistance Program based on the federal income guidelines for poverty are referred to the MAP Program. The actual number of eligible or certified families with children is unknown as the MAP data system does not provide this information. With the new Health Care Reforms, the Medicaid system in the Virgin Islands may be able to have the cap removed to increase funding for more eligible families. The Governor of the VI has established a Health Reform Task Force to work on increasing access to MAP and insurance and eligibility. The task is also try to come up with ways to implement the Affordable Care Act. The Commissioner of Health is on that task force along with the MAP Director and the Health District Officer.

**c. Plan for the Coming Year**

All children registered in the Title V program receive services regardless of insurance availability or ability to pay. Uninsured children will continue to be provided financial assistance for access to diagnostic, specialty and sub-specialty care based on need and availability of resources. Families without health insurance will continue to be referred to the Medical Assistance Program to determine eligibility. The MCH program will continue to provide care coordination services to children with special health care needs who access services.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	10	10	10	10	10
Annual Indicator	4.4	11.8	13.6	9.6	11.9
Numerator	186	276	397	216	307
Denominator	4261	2339	2923	2256	2578
Data Source		WIC/PedNSS	WIC/PedNSS	WIC Program	WIC Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	15	15	15	15	15

**Notes - 2011**

All data for this measure was obtained from the WIC Program for this reporting year.

**Notes - 2010**

All data for this measure obtained from the WIC Program for reporting year.

**Notes - 2009**

Data not available from WIC Program at the time of submission for this measure.

**a. Last Year's Accomplishments**

The WIC program continued implementation of the new food packages according to Federal Program Regulations which were designed to help fight the trend of increased obesity and chronic disease incidence in the nation. Most of the year's activities focused around the implementation of these new food packages, as major programmatic revisions had to be made to incorporate the foods offered in policies and procedures as well as in the WIC IT system.

New foods offered include whole grain bread, fruits and vegetables, and soy beverage and tofu for those participants who are milk intolerant. All children and women participants except 1 year olds had their milk option changed to reduced or non fat milk.

Numerous staff and vendor trainings about the new food packages occurred throughout the year. Nutritionists developed participant nutrition education materials to educate participants about the new food packages, about using more fruits and vegetables in their diets and changing to reduced fat milk.

WIC staff continued to help participants identify correct portion sizes through nutrition education hands on activities such as a session held in one clinic. Clients had to identify the standard serving size of 4 foods displayed. receive a prize if the got 3 out of 4 correct. This client centered approach embraces the new WIC Value Enhanced Nutrition Assessment (VENA) philosophy which focuses on desired health outcomes rather than deficiencies. It encourages the use of methods that are participant led.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide participants education on basic nutrition and importance of physical activity.	X			
2. Continue to implement an intervention strategy that provides nutrition education to at-risk participants	X		X	
3. Continue to educate parents through the VI Dept of Education's Parent University Initiative utilizing the Parent Education Curriculum of the WE CAN Program		X	X	
4. Partner with the University of the VI Extension Center that provides on-going education and outreach for the community with respect to good nutritional habits.		X	X	
5.				
6.				
7.				
8.				
9.				

10.				
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**b. Current Activities**

Clinic staff continues to provide nutrition education activities for WIC participants to assist them to prepare healthy meals for their families and to make healthy choices that will keep them in good health.

WIC participants receive nutrition education according to risk and program policies and procedures that would enable them to make informed decisions about their nutritional health. The MCH program will continue to partner with the WIC program and refer patients that are WIC eligible and have BMI > 25 for nutrition counseling by the WIC program.

The Department of Human Services has two initiatives that target childhood obesity: The "Let's Move Childcare" under the Office of Childcare and Regulatory Services and the "I Am Moving, I Am Moving" under the Head Start program - all initiatives that support the WIC population and their families.

**c. Plan for the Coming Year**

The MCH program will support WIC in ensuring that their clients are certified and receive nutrition services that include nutritional assessment, counseling and education according to established guidelines.

The WIC program will continue to revise its policies and procedures so that they are compatible with WIC on the Web (WOW) functions and the Value Enhanced Nutrition Assessment (VENA) and share these policies and procedures with MCH programs.

The WIC program will continue to train staff and implement changes necessary for the VENA requirements in order to continue to provide optimal nutrition services for their clients.

WIC Program staff will continue to provide participants education on basic nutrition and the importance of physical activity individually and in interactive group sessions..

The WIC program will continue to provide specialized food packages based on individual needs as well as food preparation classes for participants.

MCH will partner with the WIC program and other partners to implement a plan to address pediatric obesity prevention and management, especially utilizing the tools provided by the WE CAN (Ways to Enhance Childhood Activity) Program.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	1	1	1	1	1
Annual Indicator	1.8	0.5	0.9	4.1	1.6
Numerator	32	10	16	14	27
Denominator	1771	1844	1755	344	1687
Data Source		Vital Records	Vital Records & Statistics	MCH 2010 Needs Assessment	KIDS Count/ Kaiser State Health Facts
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1	1	1	1	1

**Notes - 2011**

Denominator: The data is based on the reported total number of pregnant females in 2009 from the Kaiser State Health Facts.

Numerator: The number of pregnant females who smoked as reported by KIDS Count Data from 2009.

The VI does not have a Pregnancy Risk Assessment (PRAMS) database.

**Notes - 2010**

Denominator obtained from MCH 2010 Needs Assessment.

Data for numerator is # of yes responses to question "Do you smoke cigarettes or use other tobacco products?"

Birth certificate data is not available at the time of submission for this measure from the DOH Office for Health Statistics.

**Notes - 2009**

Denominator obtained Office for Health Statistics. Data for numerator obtained from the Office for Vital Records & Statistics.

This is provisional pending final tabulation and report; reflects whether mother smoked at any time during pregnancy and not specifically the third trimester.

**a. Last Year's Accomplishments**

Data is not available from the DOH Office for Health Statistics for CY 2011. The Virgin Islands does not participate in the Pregnancy Risk Assessment Monitoring (PRAMS) System. However data from KIDS Count data for 2009 shows that 2% (27 of 1,687) of pregnant women reported smoking at any time during their pregnancy. The Prenatal Clinics provided information about the risks of smoking during pregnancy, and counseling on smoking cessation. All prenatal clients are encouraged to participate in the Text4Baby program, a National Program that provides mothers with tips and information to improve pregnancy outcomes. This National Program was adopted by the Virgin Islands' First Lady, Cecil deJongh, with the VI Early Childhood Advisory Council (ECAC). Posters, brochures and educational material for Text4Baby were posted within the Prenatal Clinics.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage cessation of tobacco, alcohol and other drug use during pregnancy	X	X		
2. Continue to provide risk screening and encourage first trimester enrollment into prenatal care.	X			

3. Provide care coordination for women at risk for poor birth outcomes through outreach activities to ensure access to prenatal care.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Prenatal care providers in the MCH and Community Health Clinics continue to promote tobacco cessation.

Prenatal clinic staff has been providing education on risky behaviors during pregnancy to all prenatal women - this includes the impact of tobacco on fetal brain development and the increased risk of preterm birth and poor birth outcomes secondary to tobacco usage.

Cessation guides and literature are provided to clients in the clinic. Referrals are regularly made to the Tobacco Prevention and Cessation Program. The 330 FQHCs have their own smoking cessation program to provide immediate assistance to prenatal patients.

The MCH program is in the process of implementing the Nurse Family Partnership (NFP) Home Visitation program on St. Thomas and overseeing the implementation of the Healthy Families America (HFA) model on St. Croix. These home visitation programs will be instrumental in providing more education to pregnant females about health habits during pregnancy for good birth outcomes.

**c. Plan for the Coming Year**

Tobacco and other drug use during pregnancy has been proven to cause poor pregnancy outcomes - infant mortality, prematurity and very low birth weight.

Tobacco cessation will lead to prevention of long term health complications and second hand smoke exposure to infants and children. The MCH programs will continue to encourage cessation of tobacco, alcohol and other drug use during pregnancy; to provide clients with education, informational materials and referrals to encourage and assist with smoking cessation.

Continue to provide risk screening and encourage first trimester enrollment into prenatal care.

In collaboration with VIPI (Virgin Islands Prenatal Incorp), the MCH Prenatal Clinics will provide care coordination for women at risk for poor birth outcomes through outreach activities to ensure access to prenatal care.

The program intends to have discussions with other health care providers to consider participating in the CDCs PRAMS system as a means of monitoring changes in maternal and health indicators and improve the health of mothers and infants by decreasing adverse outcomes.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	2	2	2	1	1
Annual Indicator	0.0	0.0	0.0	0.0	88.2
Numerator	0	0	0	0	7
Denominator	8751	8534	8138	8451	7936

Data Source		Vital Records	VICS / Vital Records & Statistics	VICS	KIDS Count/VICS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1	1	1	1	1

**Notes - 2011**

Numerator: the number reported reflects the total number of teen deaths that include suicide as reported by KIDS Count Data Center. The reported number of suicide attempts 16% (11.4% of females and 5.2% of males) of VI youth ages 15- 19 years in 2007 as reported by KIDS Count Data.

This data is not currently available from Vital Statistics.

The denominator is from the VI Community Survey for the number of youths ages 15 - 19 years of age.

**Notes - 2010**

Denominator obtained from 2008 VI Community Survey.

Data for numerator not available from the Office for Vital Records & Statistics as the time of submission for this measure. Suicide may be reported or certified as accidental death, homicide or other cause of death. While anecdotal information / statistics is available regarding suicide deaths in this population, they are not identified or reported as such.

**Notes - 2009**

Denominator obtained from VI Community Survey.

Data for numerator obtained from the Office for Health Statistics.  
Deaths due to suicide may be reported or miscoded as accidental or homicide.

**a. Last Year's Accomplishments**

The rates for youth suicide in the VI are unknown. Official data is not available from the Bureau of Health Statics; however KIDS Count data reports the number of suicide attempts. KIDS Count Data report that in 2007, 11.4% of VI female youth have attempted suicide and 5.2% of VI male youth have attempted suicide. 7/7936 youth in 2009 age 15-19 years of age died, but the deaths include homicide, MVA and suicide deaths.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Address the need for community awareness and education on youth suicide prevention				X
2. Develop and implement a referral plan to improve opportunities for children and adolescents to receive		X		X

assessment, evaluation and treatment.				
3. Establish a data base that will allow for tracking the actual number of suicides occur in the territory				X
4. Utilize better screening techniques to identify youth that are at risk for suicide.			X	X
5. provide additional training for staff in identifying risk factors associated with teenage suicide				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Lutheran Social Services has established a hot-line (TEEN-LINE). This line provides confidential, free phone counseling and encourages teens to be aware of suicide symptoms in others they know or themselves.

DOH Children's Mental Health Services continue to provide screening and treatment on a limited basis due to a lack of providers.

This division provides services to approximately 110 children ages 1 -- 17. These services include individual, family and group therapy; monitoring of medication and psychiatric evaluations. The Division continues to provide comprehensive community-based mental health to children, adolescents and adults in the Frederiksted catchment area. The Child & Family Therapist continue to provide much needed services to the substance abuse and child and adolescent populations.

**c. Plan for the Coming Year**

Conduct a follow-up survey to those programs which self-identify as serving MCH populations and assessing social/emotional health in MCH populations. More specifically, the survey will identify (a) protocols, standards and guidelines for screening and referral; (b) screening tools currently being used to assess social/emotional health; (c) training provided to develop skills; (d) data sources and types of data collected on screening and referrals; (e) needs for services by population group; and (f) partners/ collaborators.

While there are services in the community available to children and youth who experience any of these issues, the information may not be readily available to them at the time of need.

Coordinated efforts need to be undertaken to address the need for community awareness and education on youth suicide prevention. A plan to improve opportunities for children and adolescents to receive assessment, evaluation and treatment must be developed and implemented.

Collaborate with appropriate agencies to educate the public and professionals about depression and youth suicide through educational conferences, radio, newspaper articles and television programs.

Assure information and referral sources for families of children requiring mental health assessment, management and treatment are disseminated to schools, community & faith-based organizations and programs or agencies where adolescents congregate, e.g. after school youth activities.

Though suicide is the 11th leading cause of death in the US, it is not proven to be among the leading causes of death in adolescents or a priority area of concern in the VI. Valid, accurate data is not available to document suicide completion. Increasing awareness through health education and promotional activities on mental health, suicide prevention and identification of at-risk children needs to be a collaborative effort with public and private agencies.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	0	0	0	0	0
Annual Indicator	0.0	0.0	0.3	0.7	33.9
Numerator	0	0	4	10	20
Denominator	1771	1844	1446	1365	59
Data Source		Vital Records	FQHC (2) and DOH (2) Prenatal Clinics	FQHC (2) and DOH (2) Prenatal Clinics	Hospital data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes		
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	0	0	0	0	0

**Notes - 2011**

There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates. A Neonatologist is available in the St. Thomas-St. John District. Level III neonates are transferred off-island.

A Territorial Perinatologist provides services in both districts. In extreme instances, mothers are transferred off-island for delivery.

Denominator obtained from total number of live births reported by the hospitals.

Numerator reflects # of VLBW < 1500 grams who delivered during the reporting period as per the hospital statistics.

**Notes - 2010**

There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates. A Neonatologist is available in the St. Thomas-St. John District. Level III neonates are transferred off-island.

A Territorial Perinatologist provides services in both districts. In extreme instances, mothers are transferred off-island for delivery.

Denominator obtained from FQHC (2) and DOH (2) Prenatal Clinics - patients receiving services

during calendar year 2010.

Numerator reflects # of VLBW < 1500 grams who delivered during the reporting period.

**Notes - 2009**

There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates. A Neonatologist is available in the St. Thomas-St. John District.

A Territorial Perinatologist provides services in both districts. In extreme instances, mothers are transferred off-island for delivery.

Level III neonates are transferred off-island.

Denominator obtained from FQHC (2) and DOH (2) Prenatal Clinics - patients receiving services during calendar year 2009.

Numerator reflects # of VLBW < 1500 grams who delivered during the reporting period.

**a. Last Year's Accomplishments**

There are no Level III facilities in the Virgin Islands. This NPM is not applicable.

A Level II nursery exists on St. Thomas and St. Croix, which are both staffed with neonatologists. Newborns requiring neurosurgery or cardiac surgery may be transferred to Puerto Rico or Florida. Coordination and communication among health care and related systems were maximized to increase service utilization, and minimize gaps and duplication. The infrastructure for provision of services was strengthened in order to make a meaningful impact on the health status of women.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. There are no Level III facilities in the Virgin Islands.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

There are no plans to open a Level III nursery in the Virgin Islands. Present arrangements will be continued.

Prenatal clinic staff will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

The Prenatal staff will continue to provide education regarding health habits and avoidance of risky behaviors to promote healthy outcomes and decrease the risks of prematurity or low births that potentiate poor neonatal outcomes.

**c. Plan for the Coming Year**

There are no plans to open a Level III nursery in the Virgin Islands. Present arrangements for maternal transport will be continued on a case by case basis.  
Educational outreach will continue within the clinics to continue to ensure healthy outcomes.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	65	65	70	70	70
Annual Indicator	62.6	36.4	36.9	37.9	38.8
Numerator	1109	672	647	623	691
Denominator	1771	1844	1755	1642	1779
Data Source		Vital Records	NBS Program/Prenatal clinics reports	NBS Program/Prenatal Clinics (4)	Prenatal clinics/FQHC/Hospital data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	70	70	70	70	70

**Notes - 2011**

Denominator reflects # live birth admissions for reporting year. Data obtained from newborn screening program/ hospitals' database.

Numerator reflects # women accessing prenatal care in first trimester.  
Prenatal clinics in the Community Health Center and the FQHCs (2) in both districts only.

Data not available for reporting years 2010 and 2011 from DOH Office for Health Statistics.

**Notes - 2010**

Denominator reflects # live birth admissions for reporting year. Data obtained from newborn screening program.

Numerator reflects # women accessing prenatal care in first trimester.  
Prenatal clinics only (4).

Data not available for reporting years 2009 and 2010 from DOH Office for Health Statistics.

**Notes - 2009**

Data for calendar year 2009 provided by the Office of Health Statistics.

Denominator reflects live births admissions reported by the NBS Program Database.

Numerator reflects number of

**a. Last Year's Accomplishments**

The MCH Unit provides primary and preventive care to pregnant women, mothers and infants. Data estimates for the MCH-St. Croix, DOH Community Health, and the FQHC's (2) prenatal clinics show that 38% of prenatal patients (691 of 1779) enrolled in prenatal care in the first trimester in CY 2011, slightly decreased from last year's reported 46% of prenatal patients (623 of 1365). 38% is a gross estimation and may in fact be an underestimation since data from the hospital prenatal clinics were not available at the time of this report. Territorial data for comparison is not available from the DOH Office for Health Statistics.

Text 4 Babies national campaign initiative still continues to be promoted within the Prenatal and MCH clinics to provide support to pregnant females.

The Early Head Start program provides home visitation services to pregnant females and in fact provided services to 24 females for FY 2011.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue partnerships with programs that encourage early enrollment in early prenatal care.	X		X	X
2. Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles	X	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Outreach activities are on-going to high or at-risk pregnant women in low-income, underserved communities by VI Perinatal, Inc. (VIPI) outreach staff and case managers who encourage women to seek care early and on a continuous basis are guaranteed the best possible outcomes for delivery.

An on-going awareness and social marketing campaign by VIPI also stresses the importance of early and adequate prenatal care in preventing preterm births and poor birth outcomes. The implementation of the Home Visitation programs such as Nurse Family Partnership (NFP) and Healthy Families America (HFA) will encourage pregnant females to continue to seek health care on a regular basis and to encourage early enrollment in prenatal care services.

**c. Plan for the Coming Year**

Continue partnerships with programs that encourage early enrollment in early prenatal care, i.e. Family Planning, VIPI, through outreach, education and awareness activities.

Prenatal clinics will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles.

The Home Visitation Programs will continue to encourage early enrollment into prenatal services.

**D. State Performance Measures**

**State Performance Measure 1:** *Increase the rate of pregnant women who enroll in prenatal care in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	600	650	650	700	700
Annual Indicator	626.2	231.0	586.4	456.4	388.4
Numerator	1109	426	1008	623	691
Denominator	1771	1844	1719	1365	1779
Data Source		Vital Statistics	Office for Health Statistics	FQHC & DOH /Prenatal Clinics (4)	FQHC/DOH & MCH Prenatal Clinic
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	700	700	750	750	750

**Notes - 2011**

This is preliminary data.

Denominator reflects the # of prenatal patients receiving services at the FQHC & DOH & MCH Prenatal Clinics (4) during calendar year 2011.

Numerator reflects # of women who received prenatal care starting in the first trimester at these clinics.

**Notes - 2010**

This is preliminary data. Denominator reflects the # of prenatal patients receiving services at the FQHC & DOH Prenatal Clinics (4) during calendar year 2010.

Numerator reflects # of women who received prenatal care starting in the first trimester at these clinics.

**Notes - 2009**

Calendar year 2009 data obtained from the DOH Office for Health Statistics.

Denominator reflects the # of

Numerator reflects # of women who reported initiating prenatal care in the first trimester.

**a. Last Year's Accomplishments**

Prenatal care is more likely to be effective if women begin receiving care early in pregnancy. Continue to provide access to prenatal care and encourage women to enroll early. Women beginning care in the third trimester and those receiving no prenatal care are at increased risk for poor pregnancy / birth outcomes.

The MCH Program continues to provide care coordination, health education and counseling to pregnant women with health and social risk factors associated with low birth weight and very low birth weight infants in efforts to improve prenatal and birth outcomes.

Referrals are made to the WIC Program to supplement diets of pregnant women, who may be nutritionally at risk based on medical and nutrition assessment and federal poverty guidelines. The Title V MCH/CSHCN Program Director served on the VIPI Board of Directors, which increased collaborative efforts.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide access to prenatal care and encourage women to enroll early	X	X		
2. Continue partnerships with programs that encourage early enrollment in prenatal care		X		X
3. Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles	X		X	
4. Pregnant women will receive appropriate number of prenatal care visits that begins in the first trimester.	X			
5. The Family Planning program will continue to provide pregnancy testing with early referral of women to prenatal care.	X		X	
6. Promote activities that HP 2020 proposed Objective MICH-10 Increase the proportion of pregnant women who receive early and adequate prenatal care. X X X				
7.				
8.				
9.				
10.				

**b. Current Activities**

The MCH Unit provides primary and preventive care to pregnant women, mothers and infants. Women have access to comprehensive reproductive health care and a referral mechanism to the Family Planning Program. MCH continues to support outreach activities that are on-going to high or at-risk pregnant women in low-income, underserved communities by VI Perinatal, Inc. (VIPI) outreach staff and case managers who encourage women to seek care early and continuous care to guarantee the best possible outcome for delivery. The implementation of the Maternal Infant and Early Childhood Home Visitation Program will be instrumental in encouraging early enrollment in prenatal services.

**c. Plan for the Coming Year**

Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles. Continue partnerships with programs that encourage early enrollment in early prenatal care, i.e. Family Planning, VIPI, through outreach, education and awareness activities. Prenatal clinics will perform appropriate risk assessment and encourage women to seek care for signs of early labor. Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles. Pregnant women will receive appropriate number of prenatal care that begins in the first trimester. The Title V MCH/CSHCN Program Director will continue to serve on the VIPI Board of Directors. The collaborative efforts of community partners will continue to sustain the VIPI's initiatives to address health disparities, access to quality care and improvement in the overall health of the community. Continue to provide outreach in populations where perinatal illness and disability rates and mortality rates are highest and who are most likely to have low incomes. The Family Planning program will continue to provide pregnancy testing with early referral of women to prenatal care. Promote postpartum follow-up and family planning to decrease unplanned pregnancies, enroll women in care and encourage pregnant women to enroll early prenatal care. Continue to encourage and promote the efforts of the Home Visitation Programs (Nurse Family Partnership and Healthy Families America) in their efforts to enroll pregnant females into prenatal care within the first trimester.

**State Performance Measure 2:** *Increase the percent of CSHCN families' participation in transition planning to at least 50%.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	35	40	45	50	50
Annual Indicator	1.2	8.9		3.6	2.6
Numerator	15	136		35	20
Denominator	1248	1530		965	784
Data Source		MCH Program		MCH Program	MCH Program
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	50	55	55	55	55

**Notes - 2011**

Denominator reflects estimate of children/adolescents with special needs receiving care at both MCH Program clinic sites ages 11-18 years of age .

Numerator reflects estimate of # who participated in any transition planning activities ages 11-18 years of age.

Transitioning activities begin at 11 years of age in MCH clinics.

**Notes - 2010**

Denominator reflects estimate of children/adolescents with special needs receiving care at both MCH Program clinic sites.

Numerator reflects estimate of # who participated in any transition planning activities.

**a. Last Year's Accomplishments**

Many children and adolescents with special health care needs are unable to maintain placement in higher education, sustain employment, or live independently and are less likely than their non-disabled peers to complete high school, attend college or to be employed. Their health care is generally managed by parents or guardians and they may have little experience managing their own health care, or understanding their medical conditions. Families may be unaware of the programs and resources that can assist. Pediatric and adult health care providers often do not communicate or collaborate to successfully transfer care from one to another.

The program utilized a plan for youth and adolescents with special health care needs transitioning to adulthood. The plan is based on the Healthy and Ready to Work model which facilitates the integration of service systems to address the health issues of this population. Public health nurses ensured appropriate referrals for all adolescent and young adult clients to the appropriate agencies for health/school/work transition. 9 young adults were successfully transitioned this fiscal year.

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

Improvement in transition activities related to increasing family /youth advocacy and connecting families/youth with information regarding community / university resources for educational and vocational planning is needed to achieve the goal of 50%.

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., V.I. Center for Independent Living, and V.I. Family Information Network on Disabilities.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage adolescents and their families to participate in transition planning	X	X		
2. Utilize a transition checklist tool based on the Healthy and Ready to Work model.	X			
3. Continue to work on the transition tool and work with youth to address medical transition issues		X		
4. Assure comprehensive and timely transition to adult health care and employment	X		X	X
5. Conduct a survey of client families and providers to measure understanding of transition planning and transitioning				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Encourage adolescents and their families to participate in transition planning. Continue training of staff to equip them to properly implement a transition plan for all Children With Special Health Care Needs. The program is working on obtaining a database that will allow for better tracking and service provision/coordination. the program will increase efforts to implement the Healthy and Ready to Work Model. The program is looking at the resources and teaching aides provided by GOT TRANSITION as an alternative means to enhance transition efforts. The program had a conference with the Department of Education (Special Education Division), Dept of Health Social Services and Vocational Rehabilitation to strengthen collaborative efforts for transitioning.

**c. Plan for the Coming Year**

Ensure that adolescents with special health care needs have a transition plan as part of care coordination.

Implement a plan to assure healthy and effective transition to adulthood including employment, healthcare and independent living activities.

Develop and implement a transition manual utilizing the tools and resources from GOT TRANSITION and prepare checklist for transition from the GOT TRANSITION resource center.

Actively seek involvement of youth in transition related training activities, i.e., workshops.

Continue collaboration with appropriate agencies to ensure transition to adulthood and independence.

Seek additional TA or resources to educate both adult and pediatric health care providers on the needs of transitioning youth and their families.

**State Performance Measure 3:** *The percent of CSHCN clients who access family support services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	50	55	55	55	50
Annual Indicator	30.0	6.5	20.0	28.9	19.9
Numerator	375	100	301	279	219
Denominator	1248	1530	1505	965	1098
Data Source		MCH Program	MCH Program	MCH Program	MCH Program
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	50	55	55	55	55

**Notes - 2011**

Denominator is based on estimate of # children with special needs receiving care at MCH program clinics during the reporting year.

Numerator is based on responses from parents in the CSHCN survey.

There is a greater demand for services including family support than the program has the capacity to provide.

**Notes - 2010**

Denominator is based on estimate of # children with special needs receiving care at MCH program clinics during the reporting year.

Numerator is based on responses from parents in 2010 needs assessment. The survey data is not representative of all CSHCN who access care at the MCH Program. There were 650 completed surveys in the 2010 needs assessment.

There is a greater demand for services including family support than the program has the capacity to provide.

**Notes - 2009**

Data reflects information from St. Thomas/ St. John district only.

**a. Last Year's Accomplishments**

Case management and care coordination services, family counseling, respite care are a few of the services needed by families of children with special health care needs. While these may be available from several sources, families may have challenges accessing them. Efforts to identify appropriate support and referral services for families with CSHCN and to provide up to date information for families relative to community resources available.

A directory of community-based services and outreach programs was compiled for use by families and providers. This was done in response to a need for a source of updated information in one document.

Efforts to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children requiring services receive them continued. A system for tracking referrals was instituted by program nurses in the St. Thomas District.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue efforts to identify appropriate support and referral services for families with CSHCN		X		X
2. Provide current information for families relative to available community resources		X		X
3. Provide families with linkages to community organizations and parent advocacy groups		X		
4.				
5.				
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10.				

**b. Current Activities**

Provide families with linkages to community organizations and parent advocacy groups. The program provided information and referral services to appropriate agencies based on families identified needs

Early Childhood Advisory Council (ECAC) has adopted the Strenghtening Families Approach which is an approach that focuses on 10 different healthy factors that promote family wellness.

Best Beginnings is an annual event that brings together service providers, community organizations and families with children less than 5 years of age to educate them on various

childhood topics. Parent Cafes were implemented at this years event in which Parents met with other parents and had an open forum.

Faith based summit was held to discuss family issues and strenghtening the community in these hard times.

The program has continued to partner with organizations such as VI HUGS ( Here to Understand and Give Support) and IIPCC ( Inter- Island Coalition for Change) to assist parents in gaining access to various support services.

**c. Plan for the Coming Year**

Continue to identify information and support needs of families through a referral network of community and faith based organizations and programs.  
 Continue to partner with parent groups, public and private agencies and service providers to build resources and increase capacity to meet family needs.  
 The program has existing collaborative partnerships with community based organizations that provide services to children and families. These include but are not limited to advocacy groups, legal services, resource and training centers, child care providers, family support and faith based organizations.  
 ontinue to assist families in accessing services based on identified needs.  
 Utilize a referral / feedback system for tracking purposes and to determine outcomes of services provided.  
 Continue efforts to implement family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families.  
 Periodically evaluate referral system to assure that it is consistent with the Title V vision to integrate and strengthen community-based programs into a system of services that is more accessible and responsive to families and communities.  
 Institute Parent Cafes and Strenghtening Families model.  
 The program will continue to engage partners such as VI HUGS ( Here to Understand and Give Support) and IIPCC ( Inter- Island Coalition for Change) to provide support services needed for families with Children With Special Health Care Needs.

**State Performance Measure 4:** *The rate per 1000 of emergency department visits and hospital admissions due to asthma in children under 14 years of age.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	5	5	5	5	5
Annual Indicator	2.0	2.9	3.3		15.9
Numerator	52	66	74		324
Denominator	25805	22697	22458		20416
Data Source		RLS & JFL Hospitals	RLS & JFL Hospitals		RLS & JFL Hospital/ VICS
Is the Data Provisional or Final?					Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	5	5	5	5	5

**Notes - 2011**

Numerator :Data from hospitals in the territory reflect in-patient admissions only. Average length of stay was 1.5 days. 294 admissions were on St. Croix, which is more industrial than St. Thomas/St.John.

Denominator: the number of children ages 0-14 years in the territory based on 2009 VI Community Survey.

**Notes - 2010**

Data for this SPM was requested from both hospitals. This was not received as of reporting date.

**Notes - 2009**

Data from both island hospitals reflects in-patient admissions only. Average length of stay was 1.5 days.

**a. Last Year's Accomplishments**

With the use of nebulizer treatments and administration of first dose of steroids in the clinic and careful follow-up, the number of ER visits and hospitalizations have decreased in this population. With continued parental and child education and use of preventative medications, the number of asthma exacerbations per year has also decreased.

Asthma education and prevention efforts were held in collaboration with organizations such as the American Lung Association (ALA), VI Chapter, the University of the Virgin Islands Cooperative Extension Program.

Asthma education education and resources were provided to families, children and school personnel.

The program encouraged utilization of asthma plans obtained from ALA , National Institutes of Health and New York State DOH by program staff.

The MCH Program utilizes the New York State Asthma action plan for parents and clinical management materials for the nurses and pediatricians to use in their education of parents. School Health activities by the VI Chapter of the ALA and DOH Office of Minority Health included: in-school care and management, and health education (child self-care education, asthma management education) using the American Lung Association's Open Airways for Schools curriculum and partnership promotion for asthma friendly school environments using the federal Environmental Protection Agency's Tools for Schools. Populations served included elementary and junior high schools and school staff.

Infrastructure-building services are ongoing in many DOH programs and include supporting education and prevention initiatives through the provision of expertise, technical assistance, and guidance in childhood asthma management and care, and provision of asthma resources to community health care providers, schools, day care facilities, children and families.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide asthma education resources to families, children and school personnel		X		X
2. Provide on-going and continuous asthma education and management to families with a focus on self-management	X	X		
3. Continue to promote use of asthma plans to families.	X	X		
4. Design, establish and implement an asthma surveillance system to obtain accurate data collection for analysis to monitor quality of care and outcomes				X
5. Promote activities to achieve HP2020 Proposed Objectives: RD-1: Reduce asthma deaths; RD-2: Reduce hospitalizations for asthma; RD-3: Reduce hospital Emergency Department visits for asthma				X

6. Provide awareness and education programs for child care providers and early childhood school personnel		X		X
7. Provide guidance in childhood asthma management and care via the provision of asthma resources to community health care providers, schools, day care facilities, children and families.		X		X
8. Provide environmental health services through the establishment of a Pediatric Environmental Health Center	X	X	X	
9.				
10.				

**b. Current Activities**

Reductions in frequent hospitalization or emergency department admissions are an indicator of the health care system's success in helping families and children manage and control asthma. In addition to the above, education on the proper use on MDI's and nebulizer treatment has been effective in children being treated appropriately. The use of handouts on asthma and asthma care has also been effective in improving parental awareness and appropriate treatment. Implement existing asthma education plan to provide on-going and continuous asthma education and management to families with a focus on self-management. Monitor outcomes of asthma education and management. Provide asthma materials and resources on environmental triggers to primary care providers, schools and other interested individuals. Collaboration with the American Lung Association (ALA), VI Chapter should be strengthened and new partnerships developed. This would provide opportunities for public health, schools and community organizations to work together to develop and implement an asthma plan including an evaluation and surveillance system.

**c. Plan for the Coming Year**

Revision of the asthma care protocol.  
 Establishing an asthma clinic in which intensive instruction and health care management will occur.  
 Re-designing a health care plan for both parents and the school for each patient with asthma in accordance for the standards of the NIH -- NHLBI.  
 Education of the school nurses about asthma and the updated guidelines for management and treatment.  
 Institution of peak flow meters in the clinics and at home for parents to be able to implement the appropriate treatment.  
 Provide awareness and education programs for child care providers and early childhood school personnel.  
 Design, establish and implement an asthma surveillance system to obtain accurate data collection for analysis to monitor quality of care and outcomes.  
 Promote awareness and prevention of asthma issues in young children through the promotion of Bright Futures guidelines as the standard for well-child care, and the promotion of medical home for all children.  
 Utilize trained child care health consultants who are also public health nurses in the Title V Program and are knowledgeable about asthma recognition and treatment; to train and assist child care providers to recognize, cope with, and prevent asthma, and to work with parents to reduce environmental triggers in the home and external environments to the extent possible.  
 Promote childhood asthma education and prevention activities for children and their families, and provide resources to assist families with asthma management skills to reduce hospitalizations. Reductions in re-hospitalization are an indicator of the health care system's success in helping families and children manage and control asthma. Through a number of DOH programs, we provide guidance in childhood asthma management and care via the provision of asthma resources to community health care providers, schools, day care facilities, children and families.

**State Performance Measure 5:** *Decrease the rate of hospitalizations related to morbidity associated with Type 1 diabetes for children up to age 19 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					10
Annual Indicator					0.0
Numerator					8
Denominator					28352
Data Source					MCH Program
Is the Data Provisional or Final?					Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	10	5	5	5	5

**Notes - 2011**

Numerator: Numbers are based on patient discharge summaries provided to the MCH clinics for each of the MCH clients with Diabetes Type I disease.

Denominator: Numbers are based on population for ages 0- 19 years.

The specific data was unavailable from the hospital at the time of reporting.

**Notes - 2010**

This is a new measure this year. There is a significant increase in the number of children in the territory diagnosed with Type 1 diabetes. The lack of a pediatric endocrinologist in the territory is allayed with the assistance of an adult endocrinologist who provides education for both children and their families. In addition, consultation is available for the pediatricians and nurses providing primary and care coordination services for these families. The MCH program is in the process of obtaining data to determine trends in hospitalization and evaluate effectiveness of the education provided to families.

Denominator reflects # of children enrolled in the MCH Program who have a diagnosis of Type 1 diabetes.

Numerator reflects # of hospitalizations reported by family.

Hospital discharge data was not available from hospitals at time of report.

**a. Last Year's Accomplishments**

There is a significant increase in the number of children in the territory diagnosed with Type 1 diabetes. The lack of a pediatric endocrinologist in the territory is allayed with the assistance of an adult endocrinologist who provides education for both children and their families. In addition, consultation is available for the pediatricians and nurses providing primary and care coordination services for these families. The MCH program has been developing a process of obtaining data to determine trends in hospitalization and evaluate effectiveness of the education provided to families. The program created the MCH Youth Ambassador Program for Diabetes which is a program to educate youth with Diabetes and their families on proper diabetic management and good nutritional habits. The program is also designed to develop these young people as advocates utilizing a youth development model. The MCH Youth Ambassador Diabetes Program has established an educational curriculum that uses both the American Diabetes Association educational plan and the Joselin Diabetes Educational Program. There are monthly sessions in

which selected topics are taught using this curriculum. Both the patients and the parents are taught primarily by an Endocrinologist, and the material includes education about carbohydrate counting, glycemic index, proper nutrition and exercise -- all topics that help to better control blood glucose levels.

Other significant topics that are covered are frequent blood glucose monitoring and proper insulin dosing.

There are currently 15 patients with Type I Diabetes enrolled in the MCH Clinics. Their age ranges from 8 years to 19 years.

The protocol for requires physical exams every six months except newly diagnosed individuals who will be monthly until stabilized. The HbA1C is also ordered every 3 months as per protocol, however because of compliance issues the HbA1c has not obtained by the patients as regularly. Nevertheless, 100% of the patients have obtained a HbA1c annually.

The average Hgb A1C for 11 patients who are consistent with visits is 8.5, and the range is 6 -- 15 over a period of 9 months. 6 out of the 11 have decreased their Hgb A1C by 0.5-1. 3 or have increased their Hgb A1C by 1-2. Those that had an increase were noted to have decrease participation in the educations sessions.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote activities that address the proposed HP Objective D-5.1- Reduce the proportion of the diabetic population with an A1c value greater than 9 percent is specific to the population 18 years and over.	X	X		
2. Continue to teach basic principles and concepts about diabetes management on a monthly basis.	X	X		
3. Continue to utilize the youth development model for the program to promote patient activity in outreach and advocacy		X		X
4. Continue to encourage compliance to improve Hgb A1C results.	X			
5. Encourage healthy nutrition and increase in physical activity	X	X		
6. Increase compliance with testing of blood glucose levels and insulin injections	X	X		
7.				
8.				
9.				
10.				

**b. Current Activities**

To continue to promote the MCH Youth Ambassador Diabetes Program and create partnerships with other agencies (Dept. of Education) and community based organizations to promote awareness and education concerning the needs of this population. Partnerships with the University of the Virgin Island Extension Corporation to provide additional nutritional education to the youth and their families. The program will continue to monitor weight and Hemoglobin A1C levels to monitor the effectiveness of the program.

**c. Plan for the Coming Year**

The goal of HP 2020 is to reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM. The proposed objective D-5.1 -- Reduce the proportion of the diabetic population with an A1c value greater than 9 percent

is specific to the population 18 years and over. The MCH & CSHCN Program is adopting this objective to address the children and adolescents ( ages 8--19 years) with Type 1 diabetes. Continue to teach basic principles and concepts about diabetes management on a monthly basis. Incorporate more participation in the teaching sessions by having the patients present a topic. Continue to utilize the youth development model for the program to promote patient activity in outreach and advocacy. Continue with the diabetic teaching and strengthen the support network of the Diabetes Youth Ambassador group. Incorporate more youth development strategies to encourage greater compliance and participation in the group. Encourage compliance to obtain HbA1c every three months as ordered to try to get better blood glucose control. Continue to reinforce the importance of complying with the protocol for physical exams and laboratory evaluations during our monthly sessions. Encourage healthy nutrition and increase in physical activity. Increase compliance with testing of blood glucose levels and insulin injections.

**State Performance Measure 6:** *Increase access to comprehensive primary and preventive health care for adolescents and pre-adolescents ages 10-19 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					10
Annual Indicator				4.0	9.0
Numerator				676	1323
Denominator				17008	14724
Data Source				VICS/MCH Program	MCH clinics/FQHC/VICS
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	10	15	15	20	20

**Notes - 2011**

Denominator obtained from 2009 VI Community Survey reflects # of 10-19 year olds in territory.

Numerator reflects # receiving services at MCH Program and FQHCs at any time during the reporting period.

**Notes - 2010**

Denominator obtained from 2008 VI Community Survey reflects # of 10-19 year olds in territory.

Numerator reflects # receiving services at MCH Program at any time during the reporting period.

**a. Last Year's Accomplishments**

In May 2011 MCH collaborated with the University of Minnesota State Adolescent Health Resource Center (SAHRC) and conducted a 2 day workshop for health care providers, agencies, organizations that serve youth in the territory. The workshop was designed to promote an understanding of adolescent development and to provide a platform for developing a strategic plan for adolescent health and healthy youth development. The strategic plan was based on the adolescent health issues identified in the needs assessment.

Continued to provide access to primary care services, particularly for the uninsured and

underinsured populations.

Coordinate and implement activities with FQHC on St. Thomas addressing the adolescent population.

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

Continue 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.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide access to primary care services, particularly for the uninsured and underinsured populations	X			X
2. Promote activities that increase access to comprehensive health services for adolescents and pre-teens (10 -19 yrs).	X	X		
3. Continue outreach activities to parents and schools that encourage annual physical exams for this population	X	X		X
4. Partner with the 330 Centers to develop an adolescent/pre-adolescent health program	X	X	X	
5. Provide training for all Health Care providers in adolescent health care issues and youth development			X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Discussions began with the FQHC on St. Thomas to address increasing access to health care for the adolescent population by creating an Adolescent Health Care Program.

Outreach activities to parents and schools continued throughout the year that encouraged annual physical exams for this population.

The Title V program continued to collaborate with non-profit organizations to initiate school based health care programs to increase access to comprehensive, health care for adolescents.

Collaboration with Family Planning and the Sexually Transmitted Disease (STD) program to increase adolescent access to gynecological services, pregnancy prevention measures continues with increasing screening for sexually transmitted diseases as well as to increase education and counseling of adolescents regarding sexually transmitted diseases.

Discussions continued with Director of State Adolescent Health Resource Center/Konopka Institute for Best Practices in Adolescent Health University of Minnesota to conduct the second phase of the adolescent conference held last year. Discussions also resumed with the Director of the Rochester LEAH program for TA in developing a comprehensive adolescent program in the territory.

**c. Plan for the Coming Year**

Coordinate and implement activities with FQHC on St. Thomas addressing the adolescent population.

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

The Title V program will continue to collaborate with the FQHC on ST. Thomas to initiate school based health care programs to increase access to comprehensive, health care for adolescents,

and provide support to the FQHC in St. Croix in their efforts to expand their school based health care program.

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 collaborate with the Dept of Education in providing direct health care services (screenings) and health care education/ training for teachers and administrators.

**State Performance Measure 7: *Percent of women who abstain from alcohol use during pregnancy.***

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					90
Annual Indicator				93.0	18.8
Numerator				278	334
Denominator				299	1779
Data Source				2010 Needs Assessment	MCH Clinics/Hospitals
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	90	95	95	95	95

**Notes - 2011**

Denominator reflects # of live births this reporting year- data obtained from the hospital admission statistics.

Numerator reflects # of women who reported abstaining from alcohol 3 months before and during pregnancy as reported on Newborn hospital admissions/discharge summaries.

Data for this measure not available from DOH Office of Health Statistics at time of report.

**Notes - 2010**

This is a new measure this year.

Denominator reflects # of respondents (prenatal patients) from 2010 needs assessment.

Numerator reflects # of women who reported abstaining from alcohol 3 months before and during pregnancy.

Data for this measure not available from DOH Office of Health Statistics at time of report.

**a. Last Year's Accomplishments**

Fetal Alcohol Syndrome (FAS) is the leading preventable cause of intellectual disabilities in children, and encompasses a multitude of physical, psychological and social challenges for the children and families it affects. The program proposes to increase the knowledge and skills of practicing health care providers, education/school staff including nurses, counselors, and social workers regarding prevention, identification of, and interventions for FAS and Fetal Alcohol Spectrum Disorders (FASDs).

Alcohol screening tools for women of child bearing age, FASD diagnostic criteria, treatment

options, and supportive resources will be utilized to enhance awareness, practical skills and comfort level in caring for children and families affected by FASDs

MCH & CSHCN Program staff participated in a workshop sponsored by the Fetal Alcohol Spectrum Disorders Southeast Regional Training Center at Meharry Medical College and DOH Division of Mental Health and Substance Abuse Treatment. The workshop provided information on FASD prevention, identification and intervention. This was instrumental in increasing awareness on the dangers and consequences of FASD among health care providers, teachers and other school professionals.

An outreach/awareness campaign was initiated during FY 2010 in prenatal clinics. This created great awareness within the pregnant female populations about the dangers of alcohol. Inquiries were made by patients about how much they could or could not drink.

Screening efforts were instrumental in monitoring infants that were exposed to alcohol in utero and placing them in Early Intervention Services (Part C-IDEA) for developmental monitoring.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and implement a plan to address FASD in the territory.				X
2. Continue FASD collaboration and future training opportunities with the Training Center and Division of Mental Health to sponsor training for health care providers, pre-school and early childhood personnel including Head Start teachers.				X
3. Continue public awareness campaigns within the prenatal and pediatric clinics; expand efforts to pre-conception females in high schools		X	X	X
4. Continue public awareness campaigns within the prenatal and pediatric clinics; expand efforts to pre-conception females in high schools	X	X		X
5. Increase public awareness at public forums and health fairs		X		X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Continue FASD collaboration and future training opportunities with the Training Center and Division of Mental Health to sponsor training for health care providers, pre-school and early childhood personnel including Head Start teachers.

Develop and implement a plan to address FASD in the territory.

Continue public awareness campaigns within the prenatal and pediatric clinics; expand efforts to pre-conception females in high schools. Collaborate with community organization and other agencies, (i.e. Family Planning Program, VIPI) in these efforts.

Increase public awareness at public forums and health fairs.

Continue screening efforts from prenatal clinics through to delivery.

The home visiting models - Nurse Family Partnership and Healthy Family America are being trained in educating pregnant females in healthy habits during pregnancy and will be instrumental in providing education on healthy practices for healthy outcomes.

**c. Plan for the Coming Year**

Continue FASD collaboration and future training opportunities with the Training Center and Division of Mental Health to sponsor training for health care providers, pre-school and early childhood personnel including Head Start teachers.  
Develop and implement a plan to address FASD in the territory.  
Continue public awareness campaigns within the prenatal and pediatric clinics; expand efforts to pre-conception females in high schools. Collaborate with community organization and other agencies, (i.e. Family Planning Program, VIPI) in these efforts.  
Increase public awareness at public forums and health fairs.  
Continue screening efforts from prenatal clinics through to delivery.  
Continue to support the home visiting models - Nurse Family Partnership and Healthy Family America who will be instrumental in providing education to pregnant females on healthy practices for healthy outcomes.

## **E. Health Status Indicators**

### **E. Health Status Indicators**

#### **Introduction**

The on-going challenges faced by the program in acquiring variable population-based data to address the

respective health status indicators continued throughout this program year.

The data system of the Medical Assistance Program (MAP) does not have the functionality to provide the data needed to meet many of these indicators. An integrated data system is not in place as yet. The MCH program remains without access or linkage to the Medical Assistance database or reports.

Challenges still remain in acquiring valid, measurable data that effectively address these indicators, monitor and evaluate trends, clinical practice outcomes or perform program assessment and planning. Addressing these issues in the MCH population and developing strategies to improve services is dependent on an aggressive data driven system with qualified data management support which is non-existent. Therefore the ability to report on the status of these indicators with valid up-to -date data remains unchanged.

Nevertheless, collaborative efforts with other agencies and organizations to increase the ability to obtain data continued throughout 2011 and will continue to be enhanced to facilitate data collection as well as continue to provide comprehensive system of healthcare.

The program is currently negotiating a contract to set-up a database system that will interface with the newborn genetic/hearing database, the home visitation database system, the DOH HER and incorporate the data from these database systems into a database that will house information from MCH clinics. The connection between all these databases will improve the program's ability to acquire the data for these indicators as well as allow the program to evaluate trends, clinical outcomes and assess and plan program services.

Health Status Indicators 01A: The percent of live births weighing less than 2,500 grams.

Low birth weight is one of the leading causes of infant mortality (LBW). LBW infants are also at higher risk for serious health complications, developmental delays, long-term disability, and poor school performance. Program staff in all public prenatal clinics encourage early and continuous prenatal care, provide education on adequate nutrition and wellness to support healthy pregnancies, and encourage risk reduction behaviors that contribute to poor birth outcomes. According to data estimates from the Bureau of Health Statistics for calendar year 2008, 5.6% of live births were below 2500 grams. This compares to 11.6% in the same period for 2007. Data was not yet available for calendar year 2009. However, data collected directly from the hospitals report that 6.9% of all infants born are low birth weight. This figure has doubled from the previous year statistics of 3.1%. This is why the territory has increased the out reach activities to high or at-risk pregnant women in low-income, underserved communities through programs sponsored

by VI Perinatal, Inc. (VIPI) outreach staff and case managers encourage women to seek care early and maintain continuous care to guarantee the best possible outcomes for delivery especially in low-income underserved communities. The population known to be below the federal poverty level is presumed eligible for Medical Assistance. However, 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. Trend data is not available. For the past few years, the VI did not have a MCH Epidemiologist or biostatistician on staff, however, the Department of Health recently hired an Epidemiologist.

In St. Thomas through the Promoting Healthy Families Initiative (PHFI), Virgin Islands Prenatal Incorp. (VIPI) doing business as, Virgin Islands Partners for Healthy Communities (VIPHC) provided service for 94 pregnant females of which 33% were high risk. Despite targeted outreach, 70% entered prenatal care in the second or third trimester. In the calendar year 2011, 66 babies were born and 89% had a normal birth weight. 80% of the 66 births were vaginal deliveries and 20% were Cesarean section. There was one fetal demise. The Home Visits with high risk pregnancy were conducted in accordance with the Partners for a Healthy Baby Home Visitation Curriculum. In St. Croix, also during the calendar year 2011, through the Health Families ... Healthy Babies Initiative (HFHBI), 84 clients were served of which 42 delivered by the end of the calendar year. Of the 42 births, 85% (36) were full term infants. 14% (6) were pre-term births and 1 pregnancy ended due to fetal demise. During the calendar year, January 1, 2011 to December 31, 2011, PHFI served a total 290 clients, 258 females and 32 males. Of this number 94, or almost 33% were high risk pregnant clients, with 70% entering prenatal care in the second or third trimester.

Health Status Indicators 01B: The percent of singleton births weighing less than 2,500 grams

The general category of low birth weight infants includes pre-term infants and infants with intrauterine growth retardation. Many risk factors have been identified for low birth weight babies including: both young and old maternal age, poverty, late prenatal care, smoking, substance abuse, and multiple births.

Data estimates from the hospitals for calendar 2011 show that 4.6% of singleton live births are low birth less than 2,500 gms as compared to the previous year which showed 3.1%. This upward trend reflects that most of the low births are not secondary to multiple gestations, but rather secondary to other causes that warrant further investigation to determine and evaluate contributing causes or strategies that have an effect on this otherwise positive outcome.

Health Status Indicators 02A: The percent of live births weighing less than 1,500 grams.

These very low birth weight (VLBW) infants are at highest risk of morbidity and mortality, long-term health complications and disabilities. Very low birth weight births are usually associated with pre-term birth. The primary risk factors for pre-terms births are prior preterm birth, prior spontaneous abortion, low pre-pregnancy weight, cigarette smoking, and multiple births. Data for calendar year 2011 shows that VLBW rate was at 3.3% of all live births, compared to 0.7% in the reporting year 2010.

Birthweight, an important indicator of infant health is directly related to a baby's survival and continuing health. Babies born weighing less than 5.5 pounds (2,500 grams) are at high risk for developmental delays, both physical and cognitive. Low birthweight babies have been shown to account for more than half the costs incurred for all newborns. While the community bears some of these costs, families of these newborns are highly affected. These babies' longer and more costly hospital stays, and the degree of parental attention and time the babies may require, can destabilize family resources and impact or curtail a mother's employment outside the home. Timely, regular prenatal care for a pregnant mother is the most effective strategy for prevention of low birthweight for babies.

(Juan Luis Hospital and Schneider Regional Medical Center nurseries)

Health Status Indicators 02B: The percent of live singleton births weighing less than 1,500 grams.

These very low birth weight (VLBW) infants are at highest risk of morbidity and mortality, long-term health complications and disabilities. Very low birth weight births are usually associated with pre-term birth. The primary risk factors for pre-terms births are prior preterm birth, prior spontaneous abortion, low pre-pregnancy weight, cigarette smoking, and multiple births. Data for calendar year 2011 shows that VLBW rate at 3.3% of all live births, compared to 1.2% in 2010. This data also demonstrates an upward trend, but most importantly that in this case, the singleton's births represent the majority of the VLBW infants. ((Juan Luis Hospital and Schneider Regional Medical Center nurseries)

Birthweight, an important indicator of infant health is directly related to a baby's survival and continuing health. Babies born weighing less than 5.5 pounds (2,500 grams) are at high risk for developmental delays, both physical and cognitive. Low birthweight babies have been shown to account for more than half the costs incurred for all newborns. While the community bears some of these costs, families of these newborns are highly affected. These babies' longer and more costly hospital stays, and the degree of parental attention and time the babies may require, can destabilize family resources and impact or curtail a mother's employment outside the home. Timely, regular prenatal care for a pregnant mother is the most effective strategy for prevention of low birthweight for babies. ( 2009 VI Kids Count Data Book Community Foundation of the VI CFVI).

Health Status Indicators 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Data for this measure is not available from the DOH Office for Health Statistics at the time of this report and there are no other reporting data sources for this HSI. Denominator obtained from the 2009 VICS.

Nevertheless, VI Kids Count 2009 Data Book reports the child death rate was 50.7 per 100,000 children. This includes deaths from all causes including illness and injury.

Health Status Indicators 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Data obtained from the VI Office of Highway Safety - Traffic Safety Facts 2009 for these indicators. 1 fatality due to motor vehicle crash in children aged 14 years and younger. The Virgin Islands Office of Highway Safety was instrumental in the passage of an amendment to Act # 7067, an act amending 20 V.I.C., chapter 41 as it relates to safety belts and child restraints. The bill now includes the usage of booster seats for children 4-8 years old, and 40-80 lbs. The Legislature passed this bill unanimously on May 29, 2009 and it was signed into law on June 11, 2009.

The Office has also established a program with the Queen Louise Home, Early Head Start program and elementary schools to educate teen mothers and others about the proper use of car seats. In this program, mothers will go through a series of presentations through the Office of Highway Safety, which they will be trained about the proper use and installations of car and booster seats. To date, over 500 parents, caregivers and children have participated in the Occupant Protection program. In 2010, the Occupant Protection program set five direct and valid goals to ensure the public would understand the programs specific interest in traffic safety. With the continuous child passenger technician and police officer trainings, program monitoring, car seat and seat check clinics, and aggressive media campaigns, our efforts are being reflected in the increased seat belt usage rate.

The Virgin Islands Office of Highway Safety has collaborated with several community partners to ensure that the safety message of buckling up is being echoed throughout the community. reported. The Division of EMS and hospital emergency departments do not collect or report data for these indicators. Targeted injury prevention education is a component of health supervision

and age appropriate anticipatory guidance provided by the MCH Program clinical staff -- physicians and nurses.

There were 2 fatalities due to motor vehicle crashes reported in the 15 -- 24 years age group. (VI Office of Highway Safety 2011 Annual Report)

Health Status Indicators 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

There was 1 fatality due to motor vehicle crashes reported in the 15 -- 24 years age group.

Health Status Indicators 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Injuries are the leading cause of death among persons aged 1 through 34 years and a significant health problem affecting the nation's children. About 50 percent of all deaths of children aged 1-14 years are due to injuries, and around 80 percent of these are from motor vehicle crashes. The Dept. of Human Services recorded 406 reported incidences of child maltreatment via child abuse (physical, sexual, emotional and mental). There is no report of the number of non-fatal injuries among children 14 years and younger.

Health Status Indicators 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Injuries are the leading cause of death among persons aged 1 through 34 years and a significant health problem affecting the nation's children. About 50 percent of all deaths of children aged 1-14 years are due to injuries, and around 80 percent of these are from motor vehicle crashes. Locally, though data is not reported regarding age and ethnicity, comprehensive information is available from the Office For Highway Safety on traffic related crash data. The data shows a high number of traffic incidents in the territory with a low number of total fatalities. Data obtained from the VI Office of Highway Safety - Traffic Safety Facts 2011 for these indicators remains consistent. 106 incidents were reported in the 14 years and younger age group with 1 fatality.

Health Status Indicators 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Injuries are the leading cause of death among persons aged 1 through 34 years and a significant health problem affecting the nation's children. About 50 percent of all deaths of children aged 1-14 years are due to injuries, and around 80 percent of these are from motor vehicle crashes. Locally, though data is not reported regarding age and ethnicity, comprehensive information is available from the Office For Highway Safety on traffic related crash data. The data shows a high number of traffic incidents in the territory with a low number of total fatalities. Data obtained from the VI Office of Highway Safety - Traffic Safety Facts 2011 for these indicators remains consistent. 103 incidents were reported in this age group.

Health Status Indicators 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia

The Family Planning Program continued their collaboration with the STD Program in the implementation of the Infertility Prevention Project (IPP). An analysis of Chlamydia testing was prepared by Cicitelli Associates, Inc., for the period of CY 2005-2009. Their analysis reveals the need to continue testing and spearhead a prevention/education campaign as positivity rates remain high at 59.8 in the adolescent population are most alarming.

The USVI STD Program does the contact tracing of partners of positive clients from all testing sites. All patients and their partners receive appropriate treatment at no cost. All sites provide

basic infertility services at Level I and include an initial interview, education, physical examination, counseling, and appropriate referral. The USVI STD program reports that between 2005 -2010, 78% of the Chlamydia cases reported were females. The 15 -19 year age group accounted for 33% of the cases. The highest reported cases of Chlamydia were observed in African American. This is an increase from 23.6% in 2009. The annual report that was submitted in 2012 regarding 2011 data showed that 591 females were positive out of 1657 tested. In the teenage group (15-19 years) 252 were positive out of 820 total positives. These numbers reflect both males and females who tested positive. This indicates that the teenage population makes up 33% of the positives. It is not clear whether this represents an increase in the actual number of positivities or better screening methods/increased screening or both. Regardless, these numbers and upward trend are alarming and support the need for comprehensive adolescent health care programs.

Health Status Indicators 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

The Family Planning Program continued their collaboration with the STD Program in the implementation of the Infertility Prevention Project (IPP). An analysis of Chlamydia testing was prepared by Cicatelli Associates, Inc., for the period of CY 2005-2009. Their analysis reveals the need to continue testing and spearhead a prevention/education campaign.

The USVI STD Program does the contact tracing of partners of positive clients from all testing sites. All patients and their partners receive appropriate treatment at no cost. All sites provide basic infertility services at Level I and include an initial interview, education, physical examination, counseling, and appropriate referral. In CY 2011 the age group 20-44 showed a average rate of 31.4% in 2011 from 20.1% in 2009.

Health Status Indicators 06A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)

Population data for this indicator obtained from the 2009 VI Community Survey, UVI Eastern Caribbean Center.

Health Status Indicators 06B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)

Population data for this indicator obtained from the 2009 VI Community Survey, UVI Eastern Caribbean Center.

Health Status Indicators 07A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

Younger or older mothers, and mothers belonging to racial and/or ethnicity minority groups may be at increased risk of adverse maternal outcomes. Identifying populations of women and their infants at risk, and implementing coordinated systems of pre-conceptual/perinatal services that assures receipt of risk-appropriate health care delivery is essential for healthy mothers and babies.

Due to the time required to receive certificates of live births and thoroughly edit files, the final live birth data for 2011 is not yet available, and may not be available until late fall 2012. Previous experience has shown that preliminary vital statistics estimates made at this time of year (the June after the reporting year) are often inexact. Therefore, vital statistics numbers for 2011 are not used in this narrative. Data for 2010 and 2011 births not available from the Office for Health Statistics at time of report. Report reflects 2009 data from the National Vital Statistic Report Vol 60, No1, Nov 3,2011.

Health Status Indicators 07B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

Younger or older mothers, and mothers belonging to racial and/or ethnicity minority groups may be at increased risk of adverse maternal outcomes. Identifying populations of women and their infants at risk, and implementing coordinated systems of pre-conceptual/perinatal services that assures receipt of risk-appropriate health care delivery is essential for healthy mothers and babies.

Due to the time required to receive certificates of live births and thoroughly edit files, the final live birth data for 2011 is not yet available, and may not be available until late fall 2012. Previous experience has shown that preliminary vital statistics estimates made at this time of year (the June after the reporting year) are often inexact. Therefore, vital statistics numbers for 2011 are not used in this narrative. Final data for CY 2009 is provided from the National Vital Statistic Report Vol 60, No1, Nov 3, 2011.

Health Status Indicators 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

The greatest racial and ethnic disparities are seen in the following causes of death in infants: disorders relating to pre-term birth and unspecified low birth weight; respiratory distress syndrome; infections specific to the perinatal period; complications of pregnancy; and sudden infant death syndrome (SIDS). Identifying at-risk populations and implementing and monitoring prevention/intervention programs will play an integral role in eliminating disparities in mortality.

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

The greatest racial and ethnic disparities are seen in the following causes of death in infants: disorders relating to pre-term birth and unspecified low birth weight; respiratory distress syndrome; infections specific to the perinatal period; complications of pregnancy; and sudden infant death syndrome (SIDS). Identifying at-risk populations and implementing and monitoring prevention/intervention programs will play an integral role in eliminating disparities in mortality.

Health Status Indicators 09A: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)

Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. The child poverty rate in the VI is at a high rate of 34.1% (2009) as compared to the National rate of 20% (2009). Children in single parent families are at an even higher risk higher risk of poverty at 59%.

Leaving school before graduation can lead to continued poverty and a higher incidence of juvenile arrests.

Many infants and children eligible for Medicaid and other State programs ( e.g. Head Start, Child Care Block Grant Program) are not enrolled. Data linkage of program files with Medicaid may identify factors associated with State program eligibility without full participation.

Health Status Indicators 09B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)

Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. . Children in single parent families are at a higher risk of poverty.

Leaving school before graduation can lead to continued poverty and a higher incidence of juvenile arrests.

Many infants and children eligible for Medicaid and other State programs ( e.g. Head Start, Child Care Block Grant Program) are not enrolled. Data linkage of program files with Medicaid may identify factors associated with State program eligibility without full participation.

Health Status Indicators 10: Geographic living area for all children aged 0 through 19 years.

Child health outcomes and the patterns of utilization of health care services can differ greatly by geographic area of living. Poor families living in metropolitan and urban areas without a regular source of coordinated health services may over utilize emergency services or present as frequent walk-ins to community or public health clinics. Access to care for the poor and under-served in rural and frontier areas is largely dependent on the number of providers available and willing to see the uninsured or accept Medicaid or CHIP. Barriers to quality health care may also include inadequate transport to care and ill-equipped health care facilities.

Health Status Indicators 11: Percent of the State population at various levels of the federal poverty level.

Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

Health Status Indicators 12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

## **F. Other Program Activities**

An important part of the Medicaid Program is the Early and Periodic Diagnosis and Treatment (EPSDT) program. EPSDT is designed to provide comprehensive preventive health care services to children from birth to 21 years of age. It also assures that treatment will be provided for problems and conditions identified during screening covered by MAP. The MCH & CSHCN Program is responsible for providing the medical component. Periodicity standards are based on national recommendations for routine child health maintenance. Provision of EPSDT services is a responsibility of the MCH & CSHCN Program and delineated in the MCH-MAP Agreement.

As a result of the MCH workshop and training session in 2010 to strengthening MCH infrastructure, the following elements are still in place:

- MCH providing leadership in the delivery of comprehensive health care for mothers and children in the territory.
- Incorporation of evidence-based practices/intervention in the public health system.
- Utilization of innovative ways to provide comprehensive, family-oriented health care to the women and children in the community given our limited resources.
- Creation of a more positive work environment
- A model of comprehensive, more preventative health care system was developed using the Bright Futures model with a restructured patient flow. This model of care is to be implemented within all the well child clinics as well as the clinics serving children with special health care needs. This model is being encouraged to be used by all health care workers providing services to mothers and children within the territory.
- Development of a life course model of health care to be implemented by 2013 within the community health care centers in the territory.
- Creation of a youth ambassador program in which teenagers with certain chronic illnesses form a group/team and not only learn about their illnesses and are encouraged to take on the responsibility of caring for themselves, but are also empowered to become educators about their illness within their schools and their community. The model program at this time is the "MCH

Diabetes Youth Ambassador Program". Other Ambassador programs to be developed will be for Sickie Cell, Asthma, and Obesity.

- Development of a Children's Reading Program within the clinics to encourage parents to read, educate and promote proper development of children from a young age. This program has been implemented through a collaborative effort between MCH and several community-based organizations.

- Development of policies and procedures to enhance MCH infrastructure.

- Revision and enhancement of the current home visitation program by implementing certain aspects of the Nurse/Family Program -- with the changes to be implemented in 2012.

- Enhance efforts to improve data collection and collaboration.

By partnering with many of the community based organizations such as VI Perinatal Inc., Inter-Island Parent Coalition for Change, and VI-HUGS, all organizations that provide support services, training information, and resources to parents, health care providers, and schools, outreach efforts were enhanced to educate clients as well as provide family support services. Continuous efforts to educate clients within the clinic setting has improved as evidence-based medicine guidelines are easily accessible via internet linkage to the AAP website and CDC website.

An awareness campaign about Fetal Alcohol Spectrum Disorders (FASD) was launched throughout the community by placing posters/brochures with information about FASD in prenatal clinics, Pediatric Clinics and within the Family Planning Clinics. Within the prenatal clinics, screening efforts were increased by assessing and documenting the amount of alcohol that each pregnant female consumes to identify these pregnancies as high risk pregnancies for FAS. This practice of documenting alcohol use during pregnancy is also done by the Pediatrician who is present at the delivery of the infant as a backup measure to identify high pregnancies for FASD.

***/2013/ In May 2011 MCH collaborated with the University of Minnesota State Adolescent Health Resource Center (SAHRC) and conducted a 2 day workshop for health care providers, agencies, organizations that serve youth in the territory. The workshop was designed to promote an understanding of adolescent development and to provide a platform for developing a strategic plan for adolescent health and healthy youth development. The strategic plan was based on the adolescent health issues identified in the needs assessment. //2013//***

***/2013/ Addressing Risky Youth Behaviors: MCH continues to partner with a faith-based organization and the Virgin Island Police Dept to go into all the public high and middle schools to educate the students about the risks of drug use, sexual promiscuity and the dangers of gang involvement. Students were provided statistics about STDs and given information about how to make wise decisions and healthy choices.***

***Addressing Obesity Issue:***

***MCH is a WE CAN (Ways to Enhance Children Activity and Nutrition) site. As a site, we partnered with the VI Dept of Education to sponsor several activities within the community to promote healthy nutritional habits and activities that would combat the problems of overeating, unhealthy eating habits and sedentary life. Using the Parent Curriculum of the WE Can Program, MCH did two (2) "5 week" (Jan- Feb 2011 and March --April 2011) parent educational sessions at the Parent University that taught parents about proper nutrition and how to incorporate daily activities and exercise into their lives and the lives of the children. Participation ranged from 3- 26 people. 7 people completed the entire 5 week course in the first session and 3 people completed the entire 5 week course in the second session. Every week participants discussed a new activity that they incorporated into their daily routine or a change made in their diets.***

***MCH participated in a community outreach Health Fair sponsored by the Dept of Education and did presentations on proper nutrition and importance of exercise in the mall in Feb 2011 and is still doing community outreach programs with the Dept of Health and within the Community - Community Outreach was conducted on June 29, 2012 utilizing the Savan's Boy's Club. MCH partnered with Dept of Education and piloted an obesity prevention program within two elementary schools targeting 15 -- 21 students.***

***Using the (HARVARD CURRICULUM) the selected children in the afterschool program were educated about healthy food choices and engaged in various activities that reinforced these principles as well as engaged in physical activities. At the end of the ten weeks, there was no weight gain in any of the children except one, and the children were able to discuss what healthy food choices were.***

***This partnership will be continued and a different set of schools will be chosen with pre- and post testing to obtain more objective data.***

***//2013//***

## **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.

1) The request for technical assistance for survey sample analyses was selected because the program uses several surveys to address the needs of the MCH population including Family Needs Questionnaire, Provider and Client Satisfaction. Data analysis and reporting techniques are not familiar to all staff who could benefit from a training on survey analysis that would include topics such as: setup of data tables, using SPSS to analyze survey data, and preparing analyses and reports.

2) Augment the implementation of a comprehensive Adolescent Healthcare system through collaboration with national program with success and best practices history. Compose a representative team of at least 3 members of the MCH/CSHCN Advisory Board and program management to visit an accomplished MCH adolescent program. TA will help further the support for start-up of the VI adolescent service program. The intent is to conduct a demonstration (collaborative) program of six months to one year, in a select location, such a local high school where services will be administered in its entirety. TA will support the framework in which this endeavor will occur.

3) Development of a transition Planning for Children With Special Health Care Needs that can be easily implemented and that is sustainable and is capable of creating a network of support groups and services for this population. The intention is to create a comprehensive program that allows children and their to move through the system easily and be ready for work and adult health care.

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

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

New and emerging issues in the delivery of health care to the maternal and child health population demand on-going staff training and education in order to continue to provide current and adequate comprehensive, culturally competent services.

The geographical location of the territory and the high costs of travel to the mainland are barriers to travel for training. Reassessment of staff training needs dictate that technical assistance training in the identified areas should be offered within the territory in order to maximize the benefits obtained.

See the complete Form 15 for the V.I. Technical Assistance request for FY 2013.



## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> <i>(Line1, Form 2)</i>	1511960	1286384	1492742		1444717	
<b>2. Unobligated Balance</b> <i>(Line2, Form 2)</i>	0	0	0		0	
<b>3. State Funds</b> <i>(Line3, Form 2)</i>	0	0	1376753		0	
<b>4. Local MCH Funds</b> <i>(Line4, Form 2)</i>	1255561	1205253	0		1205253	
<b>5. Other Funds</b> <i>(Line5, Form 2)</i>	140000	140000	0		171500	
<b>6. Program Income</b> <i>(Line6, Form 2)</i>	0	0	0		0	
<b>7. Subtotal</b>	2907521	2631637	2869495		2821470	
<b>8. Other Federal Funds</b> <i>(Line10, Form 2)</i>	0	500000	600000		1815357	
<b>9. Total</b> <i>(Line11, Form 2)</i>	2907521	3131637	3469495		4636827	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	436128	324028	447822		423266	
<b>b. Infants &lt; 1 year old</b>	436128	324028	447823		423267	
<b>c. Children 1 to 22 years old</b>	872256	842056	895644		564355	
<b>d. Children with</b>	872257	850773	895645		987315	

<b>Special Healthcare Needs</b>						
<b>e. Others</b>	0	0	0		141089	
<b>f. Administration</b>	290752	290752	182561		282178	
<b>g. SUBTOTAL</b>	2907521	2631637	2869495		2821470	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	0		100000		65357	
<b>c. CISS</b>	0		0		0	
<b>d. Abstinence Education</b>	0		0		0	
<b>e. Healthy Start</b>	0		0		0	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	0		0		0	
<b>h. AIDS</b>	0		0		0	
<b>i. CDC</b>	0		0		0	
<b>j. Education</b>	0		0		0	
<b>k. Home Visiting</b>	0		0		1500000	
<b>k. Other</b>						
<b>Newborn Hearing</b>	0		0		250000	
<b>MCHIEHV</b>	0		500000		0	

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	2482521	2366637	2589495		2539322	
<b>II. Enabling Services</b>	125000	75000	50000		56291	
<b>III. Population-Based Services</b>	100000	60000	80000		84637	
<b>IV. Infrastructure Building Services</b>	200000	130000	150000		141220	
<b>V. Federal-State Title V Block Grant Partnership Total</b>	2907521	2631637	2869495		2821470	

**A. Expenditures**

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

The budget for the Maternal Child Health Block Grant was developed by the Program Director, Assistant Director and Territorial Financial Management Coordinator. 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 3, Form 4, and Form 5). 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.

**B. Budget**

Federal funding through the Title V MCH Block Grant provides needed support to program efforts. Funding for State Systems Development Initiative is \$165,357; for the Newborn Screening Program is \$250,000; and for the Home Visitation Program is 1,500,000. An anticipated increase in the state match is budgeted to cover increases negotiated between the local government and employee unions. Local matching funds are used to cover the increases in salaries.

The Virgin Islands Department of Health budget a total of \$2,821,470 for FY 2013. These funds are broken down as follows:

	Amount	Percent
Federal Title V	\$1,444,717	51%
State	\$1,376,753	49 %

There is a 30/30/10 minimum funding requirement for federal funds. A waiver of this requirement is not requested during this budget year. Of the FY 2012 estimated Federal Title V allocation, the allocations are as follows:

Preventive and Primary Care for Children	\$433,415	(30%)
Federal Title V	\$866,830	(60%)
Title V Administrative Costs	\$144,472	(10%)

Local matching funds include an additional \$100,000 for the leasing of clinic space on St. Thomas. The MCH & CSHCN Program in the V.I. does not receive its program income for operating expenses. Clinic revenues are deposited into the Health Revolving Fund from which a portion is appropriated in the subsequent fiscal year.

Funds will pay for personnel costs attributable to program administration for the federally budgeted positions of MCH & CSHCN Director and Assistant Director. These funds will also pay for inter-island travel, training, maintenance of office equipment, administrative office space, and utilities required for the appropriate administration of the program. Funds will be utilized to maintain clean and healthy facilities for all employees and consumers to enter and receive services.

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

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

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

/2012/ The program continues to support non-essential support staff who are not direct service providers. This has decreased the availability of funds for service provision for uninsured

children with special needs and limits the ability of the program to recruit professional service providers, i.e. physicians, nurses. //2012//

/2013/ The program no longer continues to support non-essential support staff who are not direct service providers. This change occurred in September 2011 in which 5 employees were laid off by the directive of the Governor as part of the VI austerity plan. There is a new Project Director who also provides health care services 8 hours a week for the High Risk Population. The New Project Director took office on February 7, 2012.//

#### 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 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.

#### Population Based 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.

#### Infrastructure Building Services

Funding to support the annual meeting of the V.I. Alliance for Primary Care & MCH Advisory Council 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.

#### Maintenance of State Effort

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

#### Fair Method of Allocating Funds

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

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

#### Targeting Funds of Mandated Title V Activities

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

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

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

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.