

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: VI

APPLICATION YEAR: 2005

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

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

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

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 June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

The Virgin Islands Department of Health invites public comments relative to the Proposed Title V Five-Year Block Grant Application for the Maternal Child Health & Children With Special Health Care Needs (MCH & CSHCN) Program. A notice is placed in local newspapers annually providing information on availability of the block grant application for public review and comment. Copies of the grant application are also available upon request to agencies and partners. Feedback from prior years indicated that the application was too large and confusing for the general public.

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### III. STATE OVERVIEW

#### A. OVERVIEW

##### OVERVIEW OF THE STATE

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 political status of the U.S. Virgin Islands, often called the "American Paradise", is that of an unincorporated territory. Residents are citizens of the United States. They elect the Governor, a non-voting Delegate to Congress, and a fifteen member Legislature.

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 approximately 50 small, mostly uninhabited islands. 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, the smaller and more depressed 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 1500 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 preserve 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 to 1 mile wide with an area of 500 acres. Water Island is separated from St. Thomas by 2 mile and is close enough to draw life support from.

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. This is a slight decrease from the 1990 U.S. Census population of 109,677. 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.

/2003/The final 2000 USVI Census data determined males represented 47.8% or 51,864 and females 52.2% or 58, 748. The median age of respondents was 33.4 years.

***/2005/Census data has not been updated since the 2000 Census and the population remains basically the same./2005/***

Table 1 below shows children and youth 0 -19 years represented 34.2% of the population or 35,093. The following categories were reported:

Population	Number	Percent
Under 5 years	8,553	7.9
5-9 years	0,176	9.4
10-14 years	9,676	8.9
15--19 years	6,688	8.0

Table 1: 2000 USVI Census Population less than 19 years

***/2005/The total population represents a 6.7% increase from the last decade; however, the number of children under the age of 5 years has decreased by 7%. This is closely tied to declining birth rates in the territory by 12% over the past 10 years. The decrease in the number of children under age 5 from 1990 to 2000 accounts for over half of the overall decline in the population under 18. Tables 1-A and 1-B show comparison data from the last decade./2005//***

Category	1990	2000	Increase/Decrease	Percent Change
Total	101,809	108,612	+6,803	+6.7%
Ages 5-19	29,837	28,540	-1,297	-4.0%
Ages 20-59	53,083	57,645	+4,562	+9.0%
Ages 60+	9,659	13,874	+4,215	43.0%

Table 1-A: 2000 USVI Census total population by age:

Category	1990	2000
Ages 5-19	29%	26%
Ages 20-59	52%	53%
Ages 60+	10%	13%

Table 1- B: Population by Percentage

It is important to know about the family structure of those we seek to serve in order to be responsive to their needs. The percentage of female-headed households in the V.I. is 46%. Of those families, 49% are with children living at home. Female-headed families with children under age 5 were the most likely to be poor at 57%.

***/2005/DHS Community Assessment 2003. A First Look at Children in the US Virgin Islands, Census 2000. KIDS Count Report, Annie E. Casey Foundation and the Population Reference Bureau, September 2002./2005//***

Ethnic Composition: The 1995 Population and Household Survey estimated the racial/ethnic composition as Blacks 76.7%, Whites 10.4%, and Other races as 12.9%. The 1995 V.I. Population and Household Survey estimates there are 90,636 persons of non-Hispanic origin and 19,041 persons of Hispanic origin. The majority of residents of Hispanic origin reside on St. Croix, with an estimated population of 13,858 persons. /2003/ 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 2)

Population	Number	Percent
Black/African American	82,750	76.2
White	14,218	13.1
Other races (2)	7,852	7.2
Two or more races	3,792	3.5

Table 2: 2000 USVI Census Population by Race

The 2000 Census estimates there are 93,416 persons of non-Hispanic origin and 15,196 persons of Hispanic origin (Table 3). The majority of Hispanic residents reside on St. Croix with an estimated population of 11,277.

Population	Number	Percent
Hispanic or Latino -Total	15,196	14.0
Puerto Rican	8,558	7.0
Mexican	308	0.3
Cuban	141	0.1
Other Hispanic or Latino	6,189	5.7

Table 3: 2000 USVI Census by Hispanic or Latino origin

The Virgin Islands is a multicultural society. The 2000 US Census shows approximately 66.8 % of the population were born in the V.I. and 33.2 % born outside of the territory. In 1995, approximately 50.5% of the population was born in the V.I. and 49.5% were born outside of the Territory according to the 1995 Population and Household Survey.

Nativity	Number	Percent
Total Native/U.S. born	72,525	66.8
Foreign born	36,087	33.2
Naturalized citizen	23,080	21.2
Not a citizen	13,007	12.0

Table 4: 2000 USVI Census Population by Nativity/Citizenship

Table 4 shows 21.2% are naturalized citizens, of which 3% entered from 1990 to 2000 and 18.2% entered before 1990. Many of the persons who migrated to the territory seeking employment have now established citizenship here.

Per Capita Income: In 1994, the per capita income in households was \$10,942 territorially. St. John had the highest per capita income of \$15,333, followed by St. Thomas at \$11,726 and St. Croix's at \$9,769.

/2003/In 2001, per capita income in households was \$13,885. Per capita income in households on St. John remained highest at \$17,282, followed by St. Thomas at \$14,318 and St. Croix at \$13,197.

Based on 1995 V.I. Population and Household Survey, 20.6% of families had incomes in 1994 below poverty levels. Poverty levels have increased in 1999 for families to 28.7%. For individuals, 32.5% have incomes below poverty (Table 5).

Population Number	below poverty level	Percent below poverty level
Families	7,635	28.7
Families with related children under 18 years	5,862	35.3
Families with related children under 5 years	2,637	41.0
Families, no husband present	4,521	44.6
Individuals	34,931	32.5

Table 5: 2000 USVI Census Poverty Status in 1999 (families).

***/2005/The percentage of poverty has shown some changes since 2000 and are shown here.***

***Island Population Poverty Rate***

***St. Thomas 51,156 31.0%***

***St. Croix 53,328 45.0%***

***St. John 4,127 10.5%***

***In the Community Assessment (CA) 2003, the decrease in the number of children under age five was noted with a 7% decrease noted from 1990 to 2000. Live birth rates have been declining steadily (12% over the last 10 years). Live birth rate data was collected from the hospitals from 1996 -- 2000 because this has had a critical impact on the Head Start eligible population.//2005//***

(Source: Department of Human Services Community Assessment: 2003)

Cost of Living Indicators: In comparative studies conducted during the late 1980's by the Departments of Commerce and Labor, it was determined that the cost of living in the U.S. Virgin Islands was significantly higher than that of the United States mainland, particularly in the following areas: Food +47%; Housing +65%; Utilities +36%; Transportation +11%; Health Services +47%. (Source: 1997 Dept. of Human Services Community Assessment). The V.I. Department of Labor's Consumer Price Index indicates an average of at least 3% cumulatively.

Educational Attainment: Table 6 shows that of the 65,603 persons 25 years and over 60.6% were high school graduates or higher and 16.7% received a bachelor degree or higher. Individuals with less

than a ninth grade education represented 18.5%, and persons who received a ninth to twelve grade education but no diploma represented 20.9%.

Educational attainment	Number	Percent
25 years and over	65,603	100
Less than 9th grade	12,133	18.5
9th to 12th grade, no diploma	13,743	20.9
High school graduate includes equivalency	17,044	26.0
Some college, no degree	9,425	14.4
Associate degree	2,269	3.5
Bachelor's degree	6,841	10.4
Graduate or professional degree	4,148	6.3

Table 6: 2000 USVI Census Educational Attainment

***//2005/Public and non-public school enrollment as of 2000 is 25,620, a decrease in 2,955 or 10% in the last 10 years. This represents 90% of the total number of children of school age. In the Virgin Islands there is a very high number of teen-agers who drop out of school -- 17% - data indicating this usually happens in the first year of high school. The majority of drop outs are male (53%). It is estimated not surprisingly, that approximately 12.6% of youth not in school are also unemployed. There is only one institution of higher learning in the Virgin Islands, the University of the Virgin Islands. There is some indication that persons are beginning to access on-line education through the Internet; however, data is not available at this time on amount or impact.//2005//***

Source: DHS Community Assessment 2003)

Language: English is the only spoken language at home for 74.4% 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 25.3% of the population 5 years and over (Table 7).

Population	Number	Percent
5 years and over	100,059	100
English only	74,740	74.7
Language other than English	25,319	25.3

Table 7: 2000 USVI Census Spoken Language

Marital Status: Table 8 shows that of 42,649 females 15 years and over, 40% have never married. Similarly, 40.1% of the men 15 years and over have never married.

Females	Number	Percent
Never married	17,092	40.1
Married	15,400	36.1
Separated	1,519	3.6
Widowed	3,147	7.4
Divorced	5,481	12.9

Table 8: 2000 USVI Census Marital Status of Women

Special Needs: Table 9 shows disability of persons (five years and over -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.

Population	Number	Percent
5 -- 20 years	29,697	100
With a disability	1,402	4.7
21-64 years	60,632	100

With a disability 11,371 18.8

65 and over 8,947 100

With a disability 3,424 38.3

Table 9: 2000 USVI Census Disability status of the non-institutionalized population

Local Area Unemployment: St. Croix's economy is primarily based on manufacturing. Major industries include Hovensa Oil Corporation, V.I. Rum Industries, St. Croix Watch Factory, and several pharmaceutical companies. St. Thomas' economy is largely based on tourism and the retail industry. In March 2000, the Divi Carina Beach Hotel & Casino was opened on the East End of St. Croix. /2004/There was some weakening in the performance of the U.S. Virgin Islands economy during 2002 reflecting the general downturn in the US economy after September 11, 2001. There was negative growth in the tourism and hospitality sector and in manufacturing. The major sectors (construction, wholesale and retail trade, finance insurance, real estate and transportation), showed some marginal improvement over 2001, but was too soft to effect overall economic growth.//2004//

***/2005/Performance over the past year was characterized by contractions in output and deepening fiscal problems. The fall in economic activity was linked to the sluggish recovery of the US economy, lingering concerns about the safety of air travel, as well as to the conflict in Iraq and the oil industry strike in Venezuela. The spill-over effects from each of these factors were transmitted to the already weak local economy. Over the next year, the Virgin Islands economic performance will be largely tied to the economic health of the national economy as well as to local economic development initiatives.//2005//***  
(USVI Bureau of Economic Research, August 2003)

/2003/Information obtained from the Bureau of Labor Statistics and the Bureau of Economic Research showed that in Fiscal Year 2001, the overall unemployment rate for the territory did not change significantly.

The territory's jobless rate was 7.1%, with un-employment on St. Croix at 7.2%, and St. Thomas-St. John at 6.2%.

Total non-agricultural employment was 44,127, a three percent increase.

Government employment accounted for 28% of non-agricultural jobs, which is a decrease of 3% from the previous year. Federal employment was 2% or 880 persons and territorial employment at 26% or 11,510 persons.

Second to government, the service sector employed the most V.I. workers. This sector accounted for 28% of the territory's employment, or 12,213 jobs. This is an increase of 3% from the previous year. The service sector includes hotels, law firms, educational centers and auto repair shops among others.

Total private sector employment accounted for 72.2% or 32,029 jobs.

Trade -- both retail and wholesale- accounted for 21% of all employed. The number of people employed in this sector was 9,461.

Construction accounts for 8% of the territory's employment. This is an increase of 3% with 3,349 jobs.

Finance, Insurance, and Real Estate accounts for 4% of the territory's employment, a slight decrease of 1% from the previous year. This sector employs 1,939 persons.

Manufacturing accounts for 5%, a slight decrease of 1% from the previous year.

Transportation, communications and public utilities remained stable for 200 and accounted for 6% of all employment. Jobs in the sector were 2,503.//2003//

/2004/Information obtained from the Bureau of Labor Statistics and the Bureau of Economic Research showed that in Fiscal Year 2002, the overall unemployment rate for the territory averaged 2% higher than the corresponding period in fiscal year 2001.

The territory's jobless rate was 8.7% , with unemployment at 10.7% on St.Croix and 7.2% for the St. Thomas/St. John district.

Total non-agricultural employment averaged 2% higher, increasing to 43,158 jobs from 42,275 jobs in the corresponding period in fiscal year 2001.

Government /public sector employment accounted for 29% of non-agricultural jobs , which is a small increase of 1% to 12,515 from 12,353. Federal employment increased slightly to 2.1% or 905 persons and territorial employment at 27% or 11,706.

Second to government, the service industry employs the most V.I. workers. This sector accounted for 26% of the territory's employment and showed a 2.5% decrease in fiscal year 2002, to 11,157 from 11,444. The downturn in the tourism and hospitality industry, especially hotel, air travel and business services following September 11 have weakened the sector's performance. The sector is expected to improve as demand grows in travel and tourist related industries. This sector includes hotels, business, legal, educational, auto and miscellaneous repair services.

Total private sector employment accounted for 71% or 30,669 jobs.

Trade -- both retail and wholesale- accounted for 22.7% of all employed. The number of people employed in this sector was 9,669. The main source of overall growth came from retail trade.

The construction sector accounts for 8% of the territory's employment. The sector had an average of 3,286 jobs in fiscal year 2002.

Finance, Insurance, and Real Estate accounts for 4% of the territory's employment, This sector employs 1,915 persons, a slight decrease from last year.

Manufacturing which accounts for 5% of nonagricultural jobs, lost nearly 150 jobs in 2002. The number of jobs averaged 2,164 compared to 2,300 in fiscal year 2001.

Transportation, communications and public utilities remained stable for 2002 and accounted for 6% of all employment. Jobs in the sector were 2,450.//2004//

(USVI Bureau of Economic Research, January 2003)

***/2005/The territory's unemployment rate rose to 9.5 % in fiscal year 2003 from 8.4% in fiscal year 2002. The rate for St. Croix increased to 12.1% from 9.5% the previous year.***

***Total non-agricultural employment averaged 2% less, decreasing to 42,309 jobs from 43,3185 jobs in the corresponding period in fiscal year 2002.***

***Government/public sector employment remained at the same level or 30% of non-agricultural jobs with 12,545 jobs from 12,518 the previous year. Federal employment showed no major changes with 919 jobs up slightly from 905 in fiscal year 2002. Local government jobs are expected to decline in fiscal year 2004 as part of the government's cost cutting measures.***

***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.***

***Total private sector employment accounted for 70% or 29,764 jobs.***

***Trade -- both retail and wholesale- accounted for 28% of all employed, an increase of 6% from the previous year. The number of people employed in this sector was 13,555. The main source of overall growth came from retail trade.***

***The construction sector accounted for 8% of the territory's employment in fiscal year 2002. The sector had an average of 3,286 jobs. As capital projects neared or reached or reached completion jobs in this sector fell 39% to 1,950. Permit value a leading indicator of growth, fell 52% in the first quarter of fiscal year 2003. This is expected to change with major hotel and casino construction, the upgrade and expansion of roads, and development of commercial and residential properties.***

***Finance, Insurance, and Real Estate accounts for 4% of the territory's employment. This sector employed 2,008 persons, a slight increase from last year.***

***Manufacturing which accounts for 5% of nonagricultural jobs, lost nearly 150 jobs in 2002. An additional 50 jobs were lost in 2003 primarily in the watch industry.***

***Transportation, communications and public utilities remained stable for 2002 and accounted for 6% of all employment. Jobs in the sector were increased by 2% in 2003 and employment is likely to remain stable in 2004.//2005//***

(USVI Bureau of Economic Research, August 2003)

General labor force trends: According to data from the Chamber of Commerce, the main reasons for the decrease in the labor force in the territory are: decrease in tourism; lack of business development;

and reduced migration from the U.S. mainland or other Caribbean islands to the territory (Source: DHS Community Needs Assessment: 1999/2000).

/2004/ The projected outlook for growth in 2003 is positive. The recovery of the US and global economies is expected to spill-over and lead to a rebound of the local economy. A number of capital projects including several hotel developments, Hovensa's plans to build a desulphurization unit and private residential construction are expected to spur growth in construction and trade sectors. Additionally, growth in business and financial services, and travel and related industries should create additional employment opportunities. //2004//

(USVI Bureau of Economic Research, January 2003)

**/2005/ The projected outlook for growth in 2004 is positive. This is due to new investments in public and private sector capital projects development. Additionally, a continuing of lower interest rate policies by the Federal Reserve is likely to support the Territory's economic expansion through real estate and business development, extension of the home buying and building market, and the expansion of financial services. //2005//**

(USVI Bureau of Economic Research, August 2003)

Mass Transit System: The VITRAN mass transit system became operational in FY95. VITRAN provides transportation between remote locals, the main towns, and along the major thoroughfares. Major cutbacks in the scheduling and operation of these buses limits the service available to the public. Private taxi-vans are frequently utilized as the primary mode of transportation.

Environment: A unique factor, which affects the territory's infrastructure, is the increased incidence of powerful hurricanes, which have struck the territory in the past decade. In 1989, the devastating Hugo struck St. Croix and destroyed 95% of the homes. In 1995, Hurricane Marilyn, a powerful category III hurricane, struck St. Thomas. On St. Thomas, 92% of the homes were damaged (habitable) or destroyed (inhabitable); on St. Croix and St. John, 71% and 86%, respectively of housing units were affected (Source: MMWR Vol.45/No.4). In 1997, Hurricane Georges, a category II caused additional infrastructure damage. Millions of dollars in disaster loans have accumulated and millions of dollars have been lost due to the impact on the tourist industry. /2002/ In November 1999, Hurricane Lenny- category II- passed south of St. Croix and caused additional damage to buildings and the infrastructure . While there were no major storms in the past two years, the territory and its residents experience the economic impact of high insurance rates.

/2004/ There were no major storms last year, however, residents continue to experience lack of affordable insurance coverage. Several insurers have left the territory severely limiting the availability of adequate and affordable coverage. //2004//

In-migration: There is in-migration of undocumented residents from neighboring Caribbean islands. Based on geographic proximity to British possessions of Tortola, British Virgin Islands, and the island of Hispaniola-Santo Domingo and Haiti, immigrants come to deliver in the Virgin Islands in order to ensure U.S. citizenship for their offspring. They are uninsured and ineligible for any formal government programs. Most of the pregnant women present without records of prenatal care. In complicated pregnancies, critical newborns are cared for at the expense of the local hospitals and ultimately the Government of the Virgin Islands. Communication difficulties are also encountered.

**/2005/ Actual numbers for undocumented residents are unavailable and estimates vary due to lack of data from reliable and knowledgeable sources. Additionally, this population is considered itinerant and constantly changing. They generally live in certain geographic areas, are non-English speaking, and access the health care system only when necessary. //2005//**

Welfare Reform: In the Virgin Islands, the programs affected by changes in the Personal Responsibility and Work Act are: Public Assistance, Food Stamp Program, Child Care and Development Block Grant, and Job Opportunities and Basic Skill Program (JOBS). The specific changes occurring in these programs are: 1) Persons receiving cash awards under the Aid to Families With Dependent Children (now called Temporary Assistance to Needy Families-TANF) have lifetime benefits for a five year period only; 2) Immigrants must have paid in 40 quarters of social security, individually or combined with a spouse, before they can receive benefits, unless they are in a special exemption category outlined in the Law; 3) Any one between the ages of 18-50 years, who are able

bodied without dependents and are not engaged in work or some work activity, can only receive Food Stamps for a period of three months in a three-year period; 4) Under the appropriations portion of Title IV Child Care, Section 418 (d), the U.S. Virgin Islands has been determined ineligible to receive an allotment from new Mandatory and Matching child care funds; 5) As a result of work requirement for recipients for TANF, referrals to the JOBS Program will increase significantly. Additional activities required will be short-term training programs and jobs.

Temporary Assistance to Needy Families State Plan became effective July 1, 1997. Changes affecting Food Stamp recipients who are able bodied became effective November, 1996. The immigrant policy became effective for Food Stamp recipients on April 1, 1997 for persons already receiving assistance. New applicants to the program were affected by the original date of enactment, August 22, 1996.

/2002/ The Department of Human Services report as of May 30, 2001 there are 160 TANF recipients enrolled in activities as follows: Education component 88, On-the-Job Training with Department of Labor 64, and placed in employment 104. The Department of Human Services summarizes the impact of Welfare Reform as follows:

A reduction in the number of persons receiving Food Stamps, resulting in the number of stamps issues and impacting the economy overall.

The work requirement for families with children will increase the cost of childcare significantly and funding in this area is extremely limited.

Several TANF recipients will become ineligible for benefits for the remainder of their lifetime effective July 2002.

/2003/ One hundred twenty nine families are being removed permanently from the welfare rolls effective July 1, 2002. One hundred twenty six of these families reside on the island of St. Croix where the economy is depressed.

The Agricultural Research, Extension and Education Reform Act of 1998 (AREERA), Public Law 105-185, changes some of alien eligibility provisions and broadens alien eligibility to make more aliens eligible for Food Stamp benefits.

***/2005/ Through educational assessments, vocational testing and interagency coordination, JOBS -- (Jobs Opportunity and Basic Skills) Program transition welfare recipients from monetary entitlement benefits and dependency to personal responsibility, work opportunity and self-sufficiency. Additionally, JOBS offers GED preparation, computerized training in partnership with the Department of Education. In FY 2002, the program reached the 1st "Five-year Lifetime Benefit" for TANF clients.***

***Number of eligible TANF clients enrolled in JOBS Program: 342 (4% Reduction from FY 2002)***

***STT/J: 73 (21%)***

***STX : 269 (79%)***

***Number of clients enrolled in Vocational Training Programs: (123 or 36% of Caseload) and a reduction of 4% from FY 2002.***

***STT/J: 34 (47% of STT/J Caseload) -- significant 34% reduction from FY 2002.***

***STX : 89 (33% of STX Caseload) -- increase of 9% from FY 2002.***

***Number having work experience -- 90 (26% of Caseload)***

***STT/J: 27 (37% of STT/J Caseload) - 18% reduction from FY 2002***

***STX : 63 (23% of STX Caseload) - 5% reduction from FY 2002***

***Number of clients placed in employment: 59 -- represents 17% of caseload***

***STT/J: 31 (42% of STT/J Caseload) -- 39% reduction from FY 2002***

***STX : 28 (10% of STX Caseload) -- small increase //2005//***

(Source: Department of Human Services Annual Report 2003)

Movements Towards Managed Care: Health Maintenance Organizations (HMOs) do not exist in the Virgin Islands. Medicaid managed care is also non-existent in the territory. The Government of the Virgin Islands, as the largest employer offers health insurance coverage to its employees. Health insurance fees and increased costs of government health insurance continue to be a barrier for low-income families.

/2002/In June 2001, the Government of the Virgin Islands renegotiated the contract for health

insurance, which resulted in increased premiums to the employees. The insurance coverage reimburses at a 80/20 ratio for care received in the territory, and 60/40 for services received outside of the territory. Employees will have the option to select the benefits package.

## **B. AGENCY CAPACITY**

### State Agency Capacity

Statutory Authority: The Virgin Islands Department of Health 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 Virgin Islands Department of Health's 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 MCH & CSHCN Program is the cornerstone for family and comprehensive health service systems.

Vision statement: The Virgin Islands Department of Health envisions health care systems and policies that assure the public's health and safety.

Mission: The Virgin Islands Department of Health is the territorial authority committed to: Assuring accessible, affordable, confidential, and comprehensive quality health care to all Virgin Islands residents and visitors; Regulating, monitoring and enforcing standards for all health services, facilities and professionals; Educating, mobilizing, and empowering the community toward the development of positive lifestyles; and Protecting the health and safety of the community.

The mission of the MCH & CSHCN Program is to promote quality health care for women, children, and families, and assure access to services for high-risk and special needs groups through planning and coordination of comprehensive health services systems.

Goals & Objectives: MCH & CSHCN goals are: (a) to assure access to comprehensive, coordinated, family-centered, culturally-competent primary and preventive health care services for all women and children, especially low income and vulnerable populations, in order to promote positive maternal and child health outcomes; (b) to improve the health of children and adolescents through comprehensive, coordinated, family-centered, culturally-competent primary and preventive care; and (c) to provide a system of coordinated, family-centered, community-based and culturally-competent care for children with special health care needs and their families.

### Program Capacity

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

For children, ages 0-21, with disabilities and chronic conditions, the program provides preventive and primary care, therapeutic and rehabilitative services. The MCH & CSHCN program offers a system of family-centered, coordinated, community-based, culturally competent care. Services are provided either directly through Title V or by referral to other agencies and programs that have the capability to provide medical, social, and support services to this population. Public Health Nurses provide parental

counseling and education regarding growth and developmental milestones, proper nutrition practices, immunizations, service/care coordination and home visiting services for high risk children and their families.

Clients with acute illnesses or who require medical procedures beyond the capability of the medical staff to provide are referred to the Emergency Department for assessment and treatment.

The territory does not have a Supplemental Security income (SSI) Program to provide 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 basis by the Title V Program when required.

Direct Care: The Title V Program provides access to quality health care by delivery of direct health care services for families that have inadequate financial resources to obtain medical insurance. This includes uninsured children of immigrant parents who have not met the residency or other legal requirements to apply for medical assistance, or who would not otherwise receive health care (See discussion under State Coordination: Medicaid).

The Charles Harwood Complex is the principal site for MCH service delivery on St. Croix. /2003/Due to the renovation of Charles Harwood in February 2002, MCH clinics were temporarily relocated to the Herbert Grigg Home for the Aged. Clinics include: Prenatal Intake for new patients in which the history, physical, risk assessment, PAP smear, and laboratory referrals are done; Midwife Clinic or Revisit Clinic for routine follow-up and counseling; Teen Prenatal and Family Planning Clinics; and Perinatal/High Risk Clinic for the management of obstetrically or medically complex cases. Patients with emergencies are referred to the Obstetrical Ward for evaluation and treatment. In-patient deliveries are performed by the hospital's Obstetricians and Midwives.

***/2005/It is anticipated that renovation of the Charles Harwood Complex will be completed by the end of Summer 2004 and all program staff will be relocated to that facility./2005//***

Diagnostic services, such as ultrasounds and laboratory services, are available at the hospitals or at private facilities. The government does not operate a public health laboratory on either island outside of the hospital facilities. /2002/ In 2001, the MCH Program partnered with the Family Planning Program to provide Chlamydia testing, via the Infertility Prevention Project. This Center for Disease Control funded program provides Chlamydia test kits to the clinics. Data to date shows an overall rate of 11% positive among patients.

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 Obstetrician performs the initial medical evaluation and manages medically complicated patients. On St. Thomas, prenatal services are administered by the Community Health Clinics with one Midwife, one Nurse Practitioner, and Perinatologist (.1FTE). The Perinatologist also serves as the Director of Women's Health and conducts clinics at East End Health Center, Frederiksted Health Center, St. Croix, and at the Myrah Keating Smith Health Center on St. John.

***/2005/There is a full-time (1FTE) Obstetrician/Gynecologist providing both prenatal and limited gynecological services. /2005//***

Patients are referred to the WIC or Community Health Nutritionists for dietary assessments, counseling, and follow-up. Dental services are provided at Charles Harwood, on St. Croix, and 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, 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. In

1999, there were 144 Physicians with active licenses to practice in the Virgin Islands. Of those licensed, fourteen (14) were Obstetricians, twelve (12) Pediatricians and eleven (11) Family Practice. /2004/As of November 2002, there are 175 physicians licensed to practice in the Virgin Islands. These included seventeen (17)Obstetricians, fourteen (14) Pediatricians and sixteen (16) Family Practice.//2004//  
(Source: V.I. Board of Medical Licensure).

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 west, and the MCH & CSHCN principal facility is located in the east at Charles Harwood Complex. In Cruz Bay, 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 CSHCN Unit identifies children who have health problems requiring intervention, are suffering from disabling, or chronic medical conditions, or are at risk. A system of public health nursing, based on specified health districts, is an integral component of providing family-centered, community health services. Sources of child-find include referrals from the Queen Louise Home for Children, Early Childhood Education, Head Start, and Private Providers. Pediatricians, Nurses, Social Workers, a Physical Therapist Assistant, an Occupational Therapist, Audiologist, and Speech Pathologist are the major providers of direct services. The Infants and Toddlers Program employ Case Managers on each island. /2002/ The Infants and Toddlers Program has completed training of six parents as "Parents as Service Coordinators".

Hospital newborns with biological, established, or environmental risks are referred to the Infant or Pediatric High Risk clinics based on satisfied 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 delay using the Denver Developmental Screening Tool. Social Workers complete an assessment of the family and home environment, existing support structures, and financial status. A diagnostic assessment and therapeutic plan is developed by the clinical staff. Through an appointment system, children with special health care needs are referred to the sub-specialty clinics by the primary care physician. The Physical Therapist serves territorially. The Speech Pathologist on St. Thomas may travel to St. Croix to provide services and conduct screening.

The integrated and coordinated comprehensive sickle cell disease program continues under the direction of the Assistant MCH Director who has oversight responsibility for a territorial integrated newborn screening program. Transition of the V.I. Integrated and Coordinated Sickle Hemoglobinopathies Program occurred without interruption in services to children and families. Public health nurses continue to follow-up this population by provision of in-kind case management/care coordination services.

Population Based-Services: The MCH & CSHCN Program offers three population-based preventive services: immunization services; the newborn genetic/metabolic screening program; and the newborn hearing screening program. Each is discussed under related Performance Measures. /2003/Funding awarded from the Centers for Disease Control and Prevention for a four year project period starting September 1, 2001, enabled continuation of newborn hearing screening under the auspices of the MCH & CSHCN Newborn Screening and Follow-up Program. The Infants & Toddlers Program continues as the primary referral source for children identified with hearing loss/impairment requiring amplification or habilitative services.

/2004/In fiscal year 2002, funding was received from the Region II Environmental Protection Agency for a public awareness and education campaign regarding asthma prevention, diagnosis and management. Activities of this initiative were accomplished with the collaboration and cooperation of several agencies and organizations.//2004//

***/2005/ Significant improvement in newborn hearing screening rates before hospital discharge***

**was noted. See discussion under Performance Measure #12. //2005//**

Direct Care/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), and the Community Nutrition Program.

**//2005/There was a noticeable, though not documented, increase in the number of uninsured children of immigrant 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.**

**//2005/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 being revised to address the need for standards and guidelines for service provision, data collection, training and quality assurance/ improvement.//2005//**

## **C. ORGANIZATIONAL STRUCTURE**

### ORGANIZATIONAL 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 July 1999. The executive staff consists of the Commissioner of Health, the Assistant Commissioner of Health, Deputy Commissioner of Public Health, the Deputy Commissioner of Fiscal Affairs, and the Deputy Commissioner of Administrative Services and Management.

The Maternal and Child Health and Children With Special Health Care Needs Program reports directly to the Commissioner of Health. 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 of MCH & CSHCN, the Program Administrator St. Croix, and the Program Administrator St. Thomas.

**//2002/By September 2001, an Assistant MCH & CSHCN Director position will be established to assist with the implementation of the strategies and programs specified in the "Plan for Case Management and Care Coordination" which responded to the 2000 Needs Assessment. This position will further develop new initiatives, monitor population-based services, such as newborn screening services, and coordinate enabling services and comprehensive systems of care.**

**//2004/Assistant Director was appointed in October 2001.//2004//**

**//2002/A strategic planning retreat for Department of Health's executive and senior management staff was held in May 2001. The final strategic plan, "Moving Forward With Public Health," was developed based on the US 2010 National Objectives. The goals are:**

**1) Maintain and improve access to quality health care services, 2) Reduce prevalence and disabilities caused by chronic disease, 3) Enforce laws and implement rules and regulations that protect health**

and ensure the safety of the community, 4) Provide health education, health promotion and community-based programs for the VI Community, 5) Enhance mental health and substance abuse prevention services, 6) Reduce the incidence and transmission of HIV/STD/TB, and 7) Enhance and improve the public health infrastructure. Quarterly Head of Division management Staff meetings are held to monitor progress and share policies and procedures.

The MCH & CSHCN Program is guided by an Advisory Council, a thirty (30)-member body 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, Medical Assistance Program, Department of Human Services, Infants and Toddlers, Department of Education, Parents, Hospital and Faith Community. The MCH Director, Assistant Director, Program Administrators and SSDI Administrator are ex-officio members.

***/2005/The Advisory Council was revitalized 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. The Council was instrumental in review of the Block Grant narrative and provided valuable input./2005//***

Hospitals: There are two public hospitals, the Governor Juan F. Luis Hospital on St. Croix, and the Roy Lester Schneider Hospital on St. Thomas. The hospitals are under the management of a Territorial Board and two District Boards established under Bill No. 20-0366, "The Virgin Islands Government Hospitals and Health Facilities Corporation Act", in 1994. The Commissioner of Health serves as a non-voting, ex-officio Board of Directors member.

In 1999, Bill No. 20-0030 granted partial autonomy to the hospitals. The Chief Executive Officer has the power to appoint the Medical Director, Chief Financial Officer, managerial personnel, health providers, and other professional and non-professional personnel. The bill further granted fiscal autonomy by establishing a Hospital and Health Facilities Fund for the purpose of receiving, managing, and disposing of monies or property on behalf of the V.I. Government Hospitals and Health Facilities Corporation. The Commissioner of Health remains with the legal authority to issue a certificate of need and license hospital facilities.

Both hospitals were built at 250-bed capacity. A level II nursery exists on St. Thomas, headed by a Neonatologist. In 1999, a Neonatologist joined the staff of the Juan F. Luis Hospital. /2002/ Infants on St. Croix are no longer transferred to St. Thomas for Intensive Neonatal Care. Newborn patients requiring neurosurgery or cardiac surgery may be transferred to Puerto Rico or Florida.

/2002/In June 2001, the Governor Juan F. Luis Hospital received accreditation from the Joint Commission on Accreditation of Hospital Organizations (JCAHO) for a three year period.

***/2005/The Roy L. Schneider Hospital on St. Thomas received accreditation from the Joint Commission on Accreditation of Hospital Organizations (JCAHO) for a three year period in December 2003./2005//***

330-Funded Community Health Centers: The Frederiksted Health Center (FHC) serves approximately 25,000 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, Prenatal, Pediatrics, Women's Health, Social Services, and Immunizations. The East End Health Center (EEHC), on St. Thomas, serves the medically under-served population on the heavily populated eastern end of the island. Services include general primary medical care, diagnostic, laboratory, and referral for diagnostic x-ray procedures, family planning, HIV testing, and immunizations. Ob-Gyn care includes gynecological care, prenatal care, antepartum fetal assessment, referral for ultrasounds, genetic counseling and testing, and postpartum care. Dental care services include preventive, restorative, and emergency.

/2002/An affiliate agreement has been signed by the Governor of the Virgin Islands, placing the governance of the health centers under the authority of the governing boards. The health centers were incorporated as not-for-profit entities. Policies regarding fiscal and personnel issues are being finalized. /2003/An Office of Primary Care has been established to coordinate Primary Care services within the Office of the Governor. A Territorial Primary Care Plan is being developed.

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.

Community Health Clinics: 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. /2003/ Community Health Clinics were temporarily relocated to the Herbert Grigg Home for the Aged, a facility located mid-island St. Croix

***/2005/This activity center screens, diagnose, and treat 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. An Epidemiology Committee meets quarterly to discuss issues or concerns related to bio-terrorism activities and emerging/infectious disease that may impact the territory including SARS and Anthrax, and collect data of epidemiological impact./2005//***

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

***/2005/This activity center is responsible for management of the ambulance system, participates in the delivery of emergency care within the hospital emergency department and the Health Department clinics. Training is provided for all levels of EMT's including Pediatric Advanced Life Support (PALS), and Advanced Cardiac Life Support (ACLS), Emergency Vehicles Operators Course (EVOC), and basic cardiac life support courses for the public. The MCH & CSHCN program was awarded an EMS-C grant for a three year period in March 2003 - February 2006, in partnership with the Division of Emergency Medical Services (EMS) to improve and increase preparedness activities to address pediatric emergencies including natural disasters, bioterrorism and mass casualty occurrences that incorporates components for pediatric needs. The purpose of this funding is to develop and implement a sustainable Emergency Medical Services-Children (EMS-C) system to strengthen the existing capability to provide pediatric emergency services. The goal is to ultimately reduce morbidity and mortality from severe illness or trauma by improving the quality of pediatric emergency medical care and supporting injury prevention./2005//***

An enhanced 9-1-1 telephone system has been implemented, allowing the dialing of a single series of numbers to request Police, Fire, or Emergency Medical Services. These calls are received at a single location, and then transferred to the respective agency. Pursuant to Act No. 6333 passed by the Legislature and approved by the Governor on December 2, 1999, effective April 1, 2000 a \$1.00 emergency service surcharge was added to all residential and commercial telephone bills. These collections were placed in a special fund, the "Emergency Services Special Fund", to be used by the Commissioner of Health, the Commissioner of Police, and the Director of Fire Services for the purchase of equipment or supplies necessary to provide, maintain, and improve emergency medical services, fire services and 911 emergency equipment.

Bioterrorism: The Department of Health is the lead agency responsible for coordinating the Public Health response in the care of a biological attack. Plans have been developed and submitted to

## D. OTHER MCH CAPACITY

### OTHER CAPACITY

Role of the Parents: Parents have played a vital role in the program planning and evaluation - quantitatively and qualitatively. Parents are involved in preliminary planning and implementation of each program. Parent representatives were part of the core committee, which developed the client survey instrument. Parents participated in the analysis of the data as members of the Alliance for Primary Care. Parents were hired to conduct interviews. There are parent representatives on the MCH Advisory Council and the V.I. Interagency Coordinating Council. "Parents as Service Coordinators" and "Parents as Surrogate Parents" are two parent involvement programs being implemented by the Infants and Toddlers Program. Parents participate in off-island training, which involves improving the quality of services being provided to infants and children with and without special health care needs.

Health Planning: A major resource is the Office of Health Planning. The Office of Health Planning is charged with the responsibility of reviewing all grant applications submitted by the MCH & CSHCN Program to ensure consistency with departmental objectives.

/2004/This office is currently without a Director. Recruitment is underway to fill this position.//2004//  
**/2005/This position remains vacant.//2005//**

Bureau of Health Statistics: The Bureau of Health Statistics maintains the vital records for the Territory. This bureau generates the health statistics, leading causes of death and maintains a cancer registry for the Virgin Islands. /2002/The Bureau is limited in capacity to analyze data because of technical and managerial personnel shortages.

/2004/A Director was appointed for this office. Efforts are underway to complete computerization of the Vital Registry system.//2004//

Office of Grants Writing and Program Analysis: The Office of Grants Writing and Program Analysis was established in 1999 to incorporate monitoring, and program evaluation. The Director searches for available and appropriate grants, reviews grants application, and monitors any conditions or terms applied to the grant. The Director also ensures that the intergovernmental review process is conducted when applicable. /2003/The position is currently vacant, although recruitment is underway.

/2004/This position remains vacant. Efforts at recruitment are continuing.//2004//

Office of Computer and Communication Services: The Office of Computer and Communication Services (OCCS) is charged with the responsibility of developing an integrated data system for the Department of Health. Computer Programmers and Systems Analysts provide technical assistance to the MCH & CSHCN Program and monitor the purchasing of all computer hardware and software. In 1999, the Community Health Clinic went live with the installation of the Health Pro Software package. On May 23, 2000, the MCH & CSHCN Clinic on St. Thomas went on line.

**/2005/ This activity center is responsible for evaluating and recommending hardware and software for all programs and divisions within the Department. These responsibilities include installation, maintenance, training and on-going support of all computer and communication systems. Additional functions include research and development of new applications for technological advancements, which reduce costs while improving efficiency. The ultimate goal of this office 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 is anticipated through this network.//2005//**

## E. STATE AGENCY COORDINATION

### 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 Education, Special Education/Early Childhood Program, Head Start Program, and Disabilities & Rehabilitation Services. The V.I. Advocacy Agency, Inc., and Legal Services provide an effective voice for disabled persons. Representatives of these agencies serve on the MCH&CSHCN Advisory Council, V.I. Interagency Coordinating Council, Community Integrated Service System, and the V.I. Alliance for Primary Care, and participate in planning and evaluating services for children with special health care needs.

***//2005/ The program continued to promote collaboration and care coordination among agencies, organizations and programs serving the special needs population.//2005//***

Infant & Toddlers Program (ITP): The ITP provides direct services to eligible children and their families when funds are not otherwise provided by public or private resources or for expansion or improvement of services that are otherwise available.

*//2003/*Part C of the Individuals with Disabilities Education Act (IDEA) is in full implementation through the ITP, and provides early intervention services to children, birth - three years of age, with developmental delays and/or disabilities and their families when funds are not otherwise provided by public or private resources or for expansion and improvement of services that are otherwise available.*//2003//*

*//2004/*ITP continues to work in collaboration with MCH&CSHCN on rendering early intervention services, such as physical therapy, speech and language pathology, occupational therapy and special instruction, transportation services, child find, referral systems, follow-up, and care coordination. The on-going collaboration and coordination is detailed in a Memorandum of Agreement between the ITP and the MCH Program. In 2002 accomplishments included: services provided to over 100 one hundred children and families; recruitment of EIS providers (part-time); revision of Transition Agreements between Part C & Part B of IDEA, and Head Start programs; training for the Parent-as-Service Coordinator Project on St. Thomas; conducted a "Family-First: Medical Home, Down's Syndrome and Autism" training for parents and professionals; partnered and collaborated with the Departments of Education & Human Services, MCH & CSHCN Program and the University Center for Excellence on Developmental Disabilities (UCEDD), to present the Annual Early Childhood Best Beginnings Conference; conducted in-service department trainings on the EIS program, and on transition processes for the Early Detection & Intervention Newborn Hearing Screening Program (EDINS).*//2004//*

***//2005/ ITP served 160 infants and toddlers this fiscal year. Use of a third party fiduciary agent to ensure timely disbursement of payments to vendors and providers of early intervention services was implemented. The Special Condition set forth significant administrative changes with the ITP. The program continues collaboration to ensure that newborns/infants identified with significant hearing loss or impairment are enrolled in EIS by 6 months of age. The ITP concluded the Infants Mental Health pilot project entitled, "Bright Beginnings", with Child Worth Support Services which provided outreach mental health services to infants and toddlers and their families. The impact on improving outcomes for children eligible for Part C services is being analyzed for continuation of the project. Advertisements are aired as part of an outreach campaign on Early Intervention Services.//2005//***

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 Individuals with Disabilities Act. The VIICC includes representatives of state public agencies, such as the Department of Health, MCH & CSHCN, Department of Human Services, Special Education/Early Childhood Education, public and private providers, advocacy agencies, parents of children with disabilities, and the V.I. Legislature. An Interagency Memorandum of Understanding between Departments of Health, Human Services, and Education coordinates the early intervention services

for children under three years.

**Head Start Screening:** The Head Start Program was created in 1965, under Title V of the Economic Opportunity Act and is currently authorized under Title I of the Human Services Reauthorization Act of 1986. In the Virgin Islands, Head Start is administered by the Department of Human Services. The program is administered through Head Start Centers throughout the Territory. /2002/ Effective June 2002, MCH will provide speech and hearing assessment and follow-up services only for Head Start. Primary medical care, in the medical home model, will be provided by the 330-community health centers.

**CISS:** In June 2000, collaboration between the Department of Human Services Child Care Division and MCH & CSHCN was initiated with the "VI Community Integrated Services System" Project (CISS). This pilot project brought together partners from Departments of Health, Human Services, Planning & Natural Resources, Fire Services and the expertise of a consultant skilled in public health planning and statistics. This three year demonstration grant is designed to establish health and safety standards for the Virgin Islands child care population; develop a territory-wide definition of health and safety components within child care settings; establish a step-by-step coordinated approach to ensuring that caregivers are knowledgeable and capable of implementing up-to-date health and safety standards, educate parents on current health and safety practices, and formulating the design for a comprehensive tracking system of children's health data. The SSDI Program Administrator is the Title V representative at planning meetings and collaborates with the CISS Project Coordinator on interagency roles and responsibilities.

/2004/ Licensing standards, rules and regulations for infant and child care facilities were developed. Health care consultants including a public health nurse from the MCH & CSHCN Program received training at UNC-Chapel Hill to provide health and safety training for child care providers.//2004//

**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 is organized into six (6) areas: prevention, assessment, intake, and evaluation; outreach, case management, and rehabilitation; crisis intervention; outpatient mental health & substance abuse and residential services. Major focus on the development of a community-based system of care began with the Child and Adolescent Service System Program (CASSP) Demonstration Grant. Achievements include the development of the V.I. definition of Severely Emotionally Disturbed (SED) children and adolescents. Mental health services to children include evaluation, assessment, and therapy. Services are provided by a psychologist and therapist, with consultation from the Department's Psychiatrist.

/2004/The Division of Mental Health applied for Children's Mental Health Services Block Grant funding to develop a comprehensive service delivery system for children and adolescents with serious emotional disturbances and their families. Services are provided in the least restricted environment and are available and accessible to all who need them. Service planning and delivery is client based and includes the participation of children and their families, with treatment based on family preservation when possible. Children and adolescents with SED needing multi-agency services will receive them in a coordinated fashion. Adequate and appropriate crisis intervention and crisis stabilization services targeted for children and adolescents are a proposed component of the system, to avoid placement in adult facilities.//2004//

**Developmental Disabilities:** The Developmental Disabilities Program is authorized under Public Law 94-103, the Developmental Disabilities Assistance and Bill of Rights Act of 1973. 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. Services provided through these grants include legal advocacy, employment, training, and special transportation. The Developmental Disabilities Council advises the Department of Human Services in the performance of these functions.

**University Affiliated Program:** In October 1994, the University of the Virgin Islands started the Virgin Islands University Affiliated Program (VIUAP). VIUAP provides inter-disciplinary training to health

professionals who work with children with developmental disabilities, including physicians, nurses, physical and occupational therapists, social workers, and other allied health professionals. In 1995, the Governor of the Virgin Islands designated the VIUAP as the lead agency for Assistive Technology responsible for developing an interagency plan of systems change and advocacy activities, designed to develop and implement a consumer responsive territory-wide program of technology-related assistance for individuals with disabilities of all ages. In 1995, the U.S. Department of Education funded the VIUAP through the Technology-Related Assistance for Individuals With Disabilities Act. The VIUAP has an advisory board on which the MCH & CSHCN Program Director is a member. The VIUAP has been active in sponsoring a number of workshops on Assistive Technology and began publication of a newsletter entitled "Harambe: Let's Pull Together". MCH & CSHCN staff participates in training workshops offered by the VIUAP.

/2004/ V.I. University Center for Excellence in Developmental Disabilities (VIUCEDD) now offers a MA degree in Assistive Technology; certificate and AA degree program in Inclusive Early Childhood Education for child care providers and professionals; ASL Interpreters training; and technical assistance to community groups serving individuals with disabilities. //2004//

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 which prepare them for competitive employment opportunities; provides supportive employment to persons with severe disabilities through Work-Able, a non-profit placement agency; provides independent living services; provides a vending stand program for visually impaired individuals; and also provides in-service training programs for professional and staff development.

***/2005/ Disabilities & Rehabilitation Services Basic Grant: Under this grant, vocational rehabilitation services conduct assessments for determining eligibility, provide counseling, guidance, referral, physical and mental restoration services, coordinate 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 the first 6 months of 2002, services provided were: on-going monitoring and support to 524 clients, and placement of 27 new persons in jobs. As a part of this grant, the program also receives funds for in-service training which in FY 2002 included workshops for Vocational Rehabilitation Staff, support staff and other DHS staff: Job Placement Strategies; Social Security; The Workforce Investment Act; Small Business Development; and Supported Employment. //2005// Source: DHS Program Summary Fiscal Year 2003)***

Women, Infants and Children Program: The Special Supplemental Nutrition Program for Women, Infants, & Children (WIC) is authorized by Public Law 95-927, as amended. 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 preventive 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.

/2003/ During FY2001, the WIC Program conducted breastfeeding training for new staff and a Lactation Counselor. Breastfeeding promotion via TV and radio commercials was planned and implemented successfully. Approximately 300 mothers enrolled in the WIC program received breastfeeding aids. Individualized assistance to solve breastfeeding was available via telephone or at clinic visits.

/2004/ Each WIC clinic is charged with assisting WIC participants in obtaining and using preventive health care services. Through either the provision of on-site health services or referral to other agencies, the WIC Program serves as a link between the participant and an appropriate healthcare provider. Enrollment in WIC has opened the door for many residents of the territory to enter the

Community Health Care System, MCH&CSHCN Program, EPSDT, Prenatal Clinic, Well-Child Clinic, Immunization, Medicaid, Family Planning, Temporary Assistance to Needy Families (TANF), Alcohol and Drug Abuse Counseling, Child Support, Head Start, and the Food Stamp Program are just some of the agencies with which WIC's personnel network for their participants' benefit. (See discussion under PM#11).//2004//

***/2005/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% breastfeeding rate among WIC post-partum participants was maintained. See discussion under NPM # 11.//2005//***

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. The mission of the 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.

/2004/ The Program experienced success in all areas of services offered in FY 2002. Teens comprised 15.1% of all visits in FY 2002. Teen attendance continues to increase for a total of 890 territory-wide in FY 2002. The goal to increase access through expansion of quality family planning services was achieved with an enrollment of 689 new patients reported between January--September 2002. (See discussion under PM#8 Current Activities.//2004//

***/2005/ Accomplishments were related to the 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. There were 7,214 visits (24.6% or 1,424 more than FY'02) where comprehensive,culturally sensitive family planning educational and medical services were provided. 2,497 adolescents were reached through direct clinic services (1,425-60.1% or 535 more than FY2002) and educational outreach sessions (1,072 or 176% more than FY'02). The increase in outreach sessions served to increase awareness to adolescents on choices and consequences as related to sexual involvement occurred despite the absence of Teen Project Coordinators on both islands. Screening for GC/Chlamydia was continued in collaboration with the VI STD/HIV/TB Prevention Program.//2005//***

V.I. Perinatal Partnership: The efforts of the V.I. Healthy Start Consortium, under the auspices of the MCH & CSHCN Division, resulted in the establishment of the VIPP. VIPP is a partnership between the Virgin Islands community including consumers, providers and community-based organizations who worked together consistently for two years developing culturally sensitive strategies to conduct client outreach and recruitment, provide case management and enhanced clinical services and expand the perinatal health system's capacity to respond to pregnant women and their families.

/2004/The VIPP Consortium and staff made great strides during the year. Fully staffed, VIPP has recruited and enrolled 252 clients and provided them with case management, outreach services and personal support. VIPP is prepared to conduct depression screening and provide group counseling sessions for clients identified in the screening. The MCH & CSHCN Assistant Director is the Title V representative on VIPP's Executive Board. See discussion under PM#18.//2004//

***/2005/VIPP continues to focus on activities to achieve broader consumer representation; identifying and enrolling clients most in need of perinatal services and implementing strategies to reduce infant mortality and morbidity on St. Croix.//2005//***

Abstinence Education Program: The Abstinence Education Program in the Virgin Islands is administered by the Adolescent Health Program (AHP) under the auspices of the Community Health

Service within the V.I. Department of Health. The Adolescent Health Director is responsible for coordinating the program. The goal of the program is to offer "sexual abstinence" as a healthy choice in the prevention of pregnancy and sexually transmitted diseases and to attract and facilitate the adolescent population, persons ages 13-19 years, in making the decision to become or remain "sexually abstinent". The abstinence education curriculum is to be promoted through the assistance of community-based agencies.

/2003/For the past 3 years an Annual Abstinence Education Youth Symposium was held on St. Thomas & St. Croix, respectively. Partnerships were retained between the Department of Health, Adolescent Health Program and Senators Lorraine L. Berry and Norman JnBaptist, of the 24th Legislature of the Virgin Islands. Overall attendance was estimated at 1800 attendees and included the target population, teachers, school guidance counselors, parents, guardians and other community-based service providers. There is continuous dissemination of literature to various youth groups upon request.

/2004/The target population for the FY'02 Youth Symposium was 7th-12th graders. The theme as in previous years related to Abstinence as a healthy lifestyle choice. The event was attended by approximately one thousand persons including teachers, school guidance counselors, parents and guardians. The AHP collaborated on many initiatives including the Ryan White All Titles Summit, health fairs and outreach/speaking engagements.//2004//

***/2005/AHP has developed and sustained partnerships with coordinators of varied youth services. An outreach initiative targeted the youth population through the development and production of public service announcements and distribution of educational material advocating sexual abstinence. The 4th Annual Youth Symposium held on both islands was well attended.//2005//***

Medicaid Program: Medicaid is authorized under Title XIX of the Social Security Act of 1935, as amended by P. L. 89-97 and is administered at the federal level by the Health Care Financing Administration. In the VI, Medicaid is administered by the Department of Health, the designated single State agency. The VI 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 purpose of the program is to make adequate health care available to children and adults who are unable to meet the cost of their medical needs. Eligibility is based on family income, available resources, and other factors. As the payor of last resort, the MCH&CSHCN Program is fiscally linked to the Medical Assistance Program (MAP). MAP functions under a \$6,080,000 cap for FY 2002 and 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, EPSDT, Family Planning, Nursing Home Services, Physician services that must be pre-authorized, and Dental services. Optional services (but covered) are Optometrist services, eyeglasses, prescribed drugs, air transportation, and respiratory therapy. Optional services (not covered) are services in institutions for mental illness, hospital transfer/air ambulance transportation, dentures prosthetic devices, physical and occupational therapy, and/or durable equipment. A revised Statement of Agreement to ensure maximum collaboration and utilization of the Bureau of Maternal and Child Health and Children With Special Health Care Needs Program under the VI State Plan for Medical Assistance has been executed by the Commissioner of Health and the Program Directors - MCH&CSHCN and MAP. This agreement provides for the coordination of care and services available to low-income populations served under Title V & Title XIX. Assistance in applying for Medicaid is provided to users of Title V services through social workers at the MCH&CSHCN facilities. Social workers inform clients of all documents required at the time of registration, i.e. birth certificates, passports, naturalization papers, etc. In addition, information is provided about the location of MAP offices, hours of operation, and how patients should apply for Medicaid. MAP eligible patients are identified at a variety of sites including outpatient ambulatory facilities, , and hospital facilities.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

SUMMARY of Health "Systems Capacity" Indicators:

01 - The rate of children hospitalized for asthma (10,000 children less than five years old).

Data required to complete this section was requested several times from both hospitals. The number of hospitalizations with asthma as the primary cause is not available. The information received from the Roy L. Schneider Hospital Pediatrics Unit on St. Thomas indicated a total of forty-five (45) admissions in fiscal year 2002 for asthma. The data was not age specific or based on the number of patients, therefore the numbers may represent multiple admissions for the same patient. Access to contractual pediatric pulmonology consultation services on-island provides comprehensive management and follow-up for children enrolled in the MCH & CSHCN program or who are referred by their primary care physician. The program collaborates with the community-based Asthma Coalition to provide education and awareness activities related to reduction of environmental triggers in homes and schools.

***/2005/Data obtained from the Roy L. Schneider Hospital on St. Thomas showed no admissions for asthma as the primary cause for hospitalization in this age group./2005//***

02 - The percent of Medicaid enrollees whose age is less than one year who received at least one 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. The Medicaid data systems in the territory lack the capability to provide specific data relating to periodic screening for eligible children who have received at least one initial or periodic screen. 466 children (3% of all MA recipients) under the age of one received medical services according to the claims data reported. Of these, 134 are reported to have received periodic screening. The data is non-specific as to age or type of screening received.

***/2005/According to data received from the Medical Assistance Program there were 583 children under the age of one eligible for EPSDT. The total eligible that received at least one screen during the year was ten (10) or 1.7%./2005//***

03 - The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one 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 eligible children less than 19 years of age whose medical expenditures were not paid because the Federal cap was exceeded. This waiver was allowed by CMS because Congress did not approve enough Child Health Insurance Program (CHIP) monies for the territories that would have allowed them to have a regular Child Health Insurance Program.

The lack of financial access for low income families also restricts their ability to choose private or primary care providers since many providers do not accept Medicaid clients.

This relates to HSCI #2 above as it affects the same population.

04 - The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent of the Kotelchuck Index.

The percent of women reported this year was 45.1 a slight decrease from 47.4 last reporting year.

***/2005/The information to report on this indicator is not available from the Office of Vital Records./2005//***

05 - Comparison of health capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

***/2005/A recent study on insurance was undertaken by the University of the Virgin Islands, Eastern Caribbean Center. A copy of the final report upon completion has been requested by this office./2005//***

06 - The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0-1), children, Medicaid and pregnant women.

Due to the federal Medicaid cap which severely restricts provision of services to all eligible families, eligibility is determined at 200% of the federal income guidelines for poverty.

***//2005/The federal Medicaid cap remains in place. There are no indications that Congress will change or increase this in the near future.//2005//***

07 - The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

A total of 2,475 children received dental services in the territory this year. The number of EPSDT eligible children is not known.

08 - The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services for the State CSHCN Program.

This HSCI is not applicable to the V.I. SSI benefits are not available to children with disabilities. The Medicaid program does not provide these services. Rehabilitative services are provided through the Department of Education Special Education Program and the Title V Program.

09(A) - The ability of States to assure that the Maternal and Child Health Program and Title V Agency have 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 yet available.

09(B)- The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products.

The USVI High School Youth Tobacco Survey was conducted in 2001. A total of 1,178 students participated in the survey. 33.9 % had ever smoked (Male=34.9%, Female=32.6%); 9% reported using any form of tobacco; 4% smoke cigarettes; 1% use smokeless tobacco. 49% want to stop smoking and 50% tried to stop smoking during the past year.

***//2005/The results of the 2002 survey were requested for this report. This information is not available.//2005//***

09(C) - The ability of states to determine the percent of children who are obese or overweight.

This information is not available.

***//2005/The Women, Infants and Children Program is currently conducting a study on childhood obesity. The focus is on WIC participants and elementary school-aged children.***

***The study is being conducted in collaboration with the School Nutrition Program, Department of Education, using body mass index as an indicator.//2005//***

## **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 Assistant 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 2002, 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

The FY 2002 central focus was promoting territorial leadership in assuring the public's health and safety for all women, children, youth, adolescents, and children with special health care needs. Mirroring the national leadership of the Maternal & Child Health Bureau, vis a vis the MCHB Strategic Plan, local efforts supported the implementation of the program plan developed in response to the needs assessment. The Maternal Child Health Bureau's goals are to eliminate barriers, health disparities, assure access to quality care, and improve the health care infrastructure. The Maternal and Child Health Bureau put forth national values, which formed the platform for framing local action within the states and territories:

Affordable and accessible high quality care for all.

Accountable, regularly monitored and evaluated evidence-based quality care.

Preventive, protective health care that address individual's physical, psychological, and social needs.

Comprehensive, coordinated care in medical homes that includes direct and enabling services.

Consumer-oriented, family-centered and culturally-competent care linked to community services.

Continually improving health care based on research, evaluation, training/education, technical assistance, and the dissemination of up-to-date information.

The subsequent elevation of the MCH priorities became a reality when the MCH & CSHCN Director was appointed the Commissioner of Health in December 2001. Additional staff were recruited to fill the position of Assistant MCH Director and Program Administrators for St. Croix and St. Thomas.

Throughout FY 2002, the MCH & CSHCN Program employed strategies 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 Partnership (Healthy Start). Collaboration was on-going with the Department of Human Services in the development of the Child Care Guidelines, a V.I. Stepping Stone Manual, Rules and Regulations for Child Care in the Virgin Islands. MCH staff were trained as child care health consultants. Partners and collaborators who were actively engaged with the program to maximize sharing of resources included individuals from the Departments of Education, Labor, Juvenile Justice, Health's Community Health Centers, Medical Assistance Program, WIC Program, Vital Statistics, Immunization, Dental Health, Family Planning, Nursing Services, Adolescent Health Abstinence Education Program, Social Services, STD/HIV/TB, 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.

Challenges in FY 2003 are related to information technology and data capacity issues. In order to address and support efforts to integrate performance measures in program activities access to adequate data collection and analysis.

## B. STATE PRIORITIES

The Virgin Islands MCH&CSHCN has captured 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 improve access to prenatal care and reproductive health services.

To increase healthy births.

To increase certification and enrollment in support programs.

To increase linkage of special needs children with needed health and community-based support services.

To assure adherence to good nutrition standards.

To improve access to primary and preventative health care services all segments of the MCH population.

To improve early childhood development while reducing child abuse.

To promote community partnerships.

To increase awareness about genetic risk.

To promote responsible sexual behavior.

These identified needs are related to specific performance measures addressed by the program and are addressed on the four levels of the MCH pyramid.

Issues related to access to care are addressed through provision of comprehensive primary and preventive care for children and adolescents which includes access to direct medical care; referrals to support programs and services; and strengthening of Title V collaborative partnerships.

Children with special health care needs have access to a source of care that provides evaluation and treatment sources; early developmental and hearing screening; early intervention services; care coordination and family support services, and access to clinical and laboratory services.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

### a. Last Year's Accomplishments

Level of service: Population-based

Population: Infants

All babies born in the community hospitals are screened for seven genetic disorders: sickle cell hemoglobinopathies, galactosemia, hypothyroidism, maple syrup urine disease, homocystinuria, G6PD, and phenylketonuria (PKU). Patients and families with positive results receive genetic counseling, case management, and comprehensive care. 98.5 percent of newborns received genetic/metabolic screening. Howard University Biochemical Genetics Laboratory continued to provide newborn genetic/metabolic screening on a contractual basis. A Hematology Clinic meets monthly and offers sub-specialty consultation with a board-certified Pediatric Hematologist. The clinic is integrated within the primary care pediatric clinics.

Contracts for services were negotiated with a board certified Pediatric Hematologist to provide consultation services on St. Thomas and St. Croix. Dr. Luis Clavell, Pediatric Hematology Consultant to the program, provided in-service education related to the use of Hydrea therapy in children, updates in fever management and emergency management of complications for the staff at both hospitals.

For the past seven years, a total of 14 children with sickle cell disease within the program have met the criteria for hydroxyurea. Prior to this treatment, these children had a history of frequent hospitalizations with an average stay of 5 days more than 3 times a year. Due to the

Hydoxyurea regimen, the total hospitalization rate for these children has dramatically reduced by an average of 94%. The newborn screening database is now fully integrated to include hearing screening.

#### b. Current Activities

A decrease in hospitalizations and complications has occurred in this special needs population. The Pediatrics Unit at the Roy L. Schneider Hospital on St. Thomas reported a total of 23 admissions for children with sickle cell disease in fiscal year 2003. There were no reported deaths during fiscal years 2002/2003. One hundred percent of newborns confirmed with sickle cell disease receive an initial pediatric hematology evaluation by four months of age and are entered into a comprehensive system of care. During calendar year 2003, eight infants were diagnosed with sickle cell or other hemoglobin variant disease. 100% are enrolled in comprehensive care and receive prophylactic penicillin. Their families received education and counseling on disease management. They are as follows: Hemoglobin SS -- 3, Hemoglobin SC -- 5. The program continues to strive to achieve 100% of screening territory-wide. For CY 2003, 98.7 % of newborns in the territory were screened.

#### c. Plan for the Coming Year

All babies born in the territory will continue to be screened. Those identified as positive will receive comprehensive diagnostic and confirmatory testing. Parent information brochure on newborn screening will be revised and translated for dissemination in prenatal and post-partum settings. Patients and families with positive results will receive 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 groups on each island will continue.

Howard University Biochemical Genetics Laboratory will continue to provide newborn genetic/metabolic screening on a contractual basis. The integrated newborn metabolic/genetic/hearing tracking and surveillance database will continue to provide useful information for statistical reporting and tracking. The program will strive to maintain the 100% follow-up rate for entry into comprehensive medical care for children diagnosed with sickle cell disease or other metabolic disorder. Oversight responsibility for the territorial integrated newborn screening program continues under the direction of the MCH Assistant Director. Public health nurses continue to follow-up this special needs population by provision of in-kind case management and care coordination services.

The program will continue to provide at least one annual in-service activity for health care providers and parents related to early and appropriate interventions to avoid serious medical complications or outcomes, and reduce morbidity and mortality due to life-threatening events.

*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)*

#### a. Last Year's Accomplishments

Level of service: Infrastructure Building / Enabling  
Population: CSHCN

The VI did not participate in the national CSHCN survey. This information is not available.

#### b. Current Activities

Family members participate on the V.I. Alliance for Primary Care, MCH Advisory Council,

Needs Assessment Planning Group and the Medical Home Task Force. Bi-lingual family members are being recruited for participation on these committees. The program did not meet the characteristics of family members of children with special health care needs as paid staff or consultants specifically for the purpose of family advocacy. However, there are several administrative staff members who are parents of special needs children who access sub-specialty services.

### c. Plan for the Coming Year

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 and support to 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 to families, family advocacy organizations and providers. In addition to the five year needs assessment, develop and administer periodic exit surveys to examine areas of family satisfaction such as care coordination, access to primary care, specialty and / or subspecialty care, participation in decision-making regarding therapies and plan of care and transition planning. Provide cultural competency training for all program staff relative to working with children and families from culturally diverse backgrounds.

Other actions to achieve this goal are to enhance coordination with Child Find activities in Part C-IDEA Program, Department of Education-Special Education, Pre-School Education & HeadStart Programs, and encourage participation through culturally sensitive and appropriate family training and education.

Training for staff, families and providers towards achievement of this goal will be provided in collaboration with a program partner, V.I. Family Information Network on Disabilities (VIFIND). This 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.

*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)*

### a. Last Year's Accomplishments

Level of Service: Enabling

Population: CSHCN

The Title V program is considered the medical home for a large percent of the CSHCN population. 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 44.6% for children under 18 years in the territory. In addition, private pediatricians and other primary care providers routinely refer families to the program for access to specialty care not otherwise available.

### 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.

Training in the Medical Home Model was accomplished this year. Participants included all MCH

& CSHCN Program staff and invited partners, family members and representatives from community-based organizations and agencies that serve this population.

A Medical Home Task Force was convened as a result of this training. The task force is comprised of members of MCH medical and nursing staff, Infant & Toddlers Program and family members. The Task Force will develop guidelines and protocols on successful implementation of medical home in the territory.

### c. Plan for the Coming Year

There is a demonstrated need for on-going professional education and training in the medical home model based on the American Academy of Pediatrics guidelines for all primary care providers in the territory. Training should include the core elements of the medical home concept as they can be adapted in the territory to meet the comprehensive needs of children and families. Existing partnerships such as those with the non-profit 330-funded health centers, private pediatricians, and the Part C-IDEA Program will be utilized to plan, develop and implement an on-going training program. A plan to promote the medical home approach through collaborations with community based organizations and professionals, i.e., child care providers will assure their assistance in encouraging families to access the comprehensive and coordinated care available in a medical home.

Technical assistance will be requested from MCHB to provide funding for consultants to provide the follow-up training and program evaluation required for implementation of medical home.

*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)*

### a. Last Year's Accomplishments

Level of Service: Direct / Enabling

Population: CSHCN

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.

### b. Current Activities

A sliding fee scale is available for clinic services. Income eligibility is based on 200% 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.

### c. Plan for the Coming Year

The program will continue to provide sub-specialty clinics to children with special health care needs utilizing contracted pediatric sub-specialists. Sub-specialists from Puerto Rico conduct monthly clinics in pediatric neurology, orthopedics, hematology, pulmonology and cardiology. All patients are eligible for these services regardless of insurance status. The availability of these services has reduced the high cost of off-island travel, enabled the clinics to be community-based, increased communication, reduced lost time from work for parents/caregivers, and enhanced the quality and continuity of care. Off-island referrals are primarily for diagnostic services such as cardiac catheterization, cardiac sonography, brainstem audio-evoked response testing, and less frequently, oncology, endocrinology, and gastroenterology services that are not available on-island for the pediatric population.

*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)*

### a. Last Year's Accomplishments

Level of Service: Infrastructure Building / Enabling  
Population: CSHCN

The VI did not participate in the national CSHCN survey.

### b. Current Activities

The program provided information and referral services to appropriate agencies based on families identified needs.

### c. Plan for the Coming Year

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.

The V.I. Alliance for Primary Care and the MCH Advisory Council, which includes members from these organizations, are the focal point for developing and maintaining these community collaboratives to promote partnerships between families and service providers.

Technical assistance is being requested to provide training on community needs assessments and community based services systems development. Will continue to assist families in accessing services based on needs.

*Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

### a. Last Year's Accomplishments

Level of Service: Enabling/Direct Care  
Population: CSHCN

VI was not included in the national CSHCN survey. This percentage is unknown. The program has developed a draft 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. The MCH Program is collaborating with the State Office of Special Education to develop goals and strategies for effective transition using a team approach.

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.

Other agencies identified as stakeholders include: 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, V.I. Center for Excellence of Developmental Disabilities, Family Voices, V.I. Center for Independent Living, and V.I. Family Information Network on Disabilities.

#### b. Current Activities

Technical assistance will be provided to MCH staff, partners, families and community agencies to facilitate the development of strategies for collaboration and communication that will assist families and adolescents in transition planning.

Training in "Transition to Adulthood" for adolescents with special health care needs was provided to all MCH Program staff in June 2004. Also invited were other government agencies and partners who provide services to this population.

#### 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.

Convene a Transition Planning team to develop and implement 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.

*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.*

#### a. Last Year's Accomplishments

Level of Service: Population Based

Population: Infants & Children

Immunization assessments completed on all children receiving services at MCH clinics.

Estimated 90% compliance with recommended vaccines as required by law for entrance into day care or school.

#### b. Current Activities

The Women, Infants and Children (WIC) Nutrition Program ensured that children participating in the program completed their immunization schedule through age 2.

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

#### c. Plan for the Coming Year

No major changes are planned for immunization services. Immunization will continue to be a vital part of every primary and preventive care visit at MCH clinics, the community health centers and other clinics.

The CSHCN Program provides primary and preventive services, as well as therapeutic and rehabilitative services to children with disabilities and chronic conditions. Included in its list of services is immunization.

The computerized central immunization registry will be continued, and vaccine will continue to be available for physicians' offices. There are mandated changes in the Vaccine for Children related to availability for insured children. These changes affect how vaccine is provided to the clinics and community health centers.

The program will continue to strive for at least 95% of all children receiving services with complete recommended immunizations by age 3 through continuous assessment of immunization status and parental education.

Annual quality assurance reviews to determine compliance with recommended immunization guidelines will be conducted. In addition to measuring compliance with vaccine schedules, the reviews will identify areas such as missed opportunities, barriers faced by parents when attempting to vaccinate their children, and provide a mechanism to document recommendations to improve rates.

In order for MCH & CSHCN clinical staff to keep up with ever changing immunization policies, management will promote attendance at training sessions and annual immunization conference. Will continue efforts to raise immunizations rates through public and provider awareness.

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

**a. Last Year's Accomplishments**

Level of Service: Population Based  
Population: Adolescents

The VI Family Planning Program provided voluntary services primarily to low-income women. The program enables individuals, mostly women of childbearing age, and families to achieve their goals for family size. The program worked to improve adolescents' understanding of human sexuality and contraception. The program provided medical evaluations, human sexuality and contraceptive counseling, infertility management, genetic counseling, referrals and health education. Improved clinic access and adolescent outreach activities that provide risk reduction education and counseling are among the services offered to this population.

The Family Planning Program continues to experience success in all areas of services offered. Efforts to provide quality, comprehensive services to the target population shows an 58.1% rate of appointments kept (total = 7,214) for family planning visits.

Teens comprised 19.8% of all visits in fiscal year 2003. This was an increase of 15.3% in teen attendance compared to the same period in fiscal year 2002. Comprehensive services including medical exams, access to comprehensive methods and counseling and testing for sexually transmitted diseases are available.

Teen attendance continues to increase for a total of 1,425 territory-wide in fiscal year 2003. A total of 45 teen outreach presentations were made to 1,072 participants. These outreach activities meet the goal of increasing awareness for adolescents on choices and consequences as it relates to sexual involvement. Outreach and education efforts are on-going on the island of St. John with an emphasis on engaging at-risk adolescents for family planning services. Screening for GC/Chlamydia in collaboration with the STD/HIV/TB Program shows a decrease in positivity rate for chlamydia.

The Abstinence Education Program is administered by the Adolescent Health Program under the auspices of the Community Health Service within the VI Department of Health. The program offers sexual abstinence as a healthy choice in the prevention of pregnancy and

sexually transmitted diseases. The program facilitates the adolescent population, ages 13 to 19 years, in making the decision to become or remain sexually abstinent. The curriculum was promoted through the assistance of community-based agencies.

The Abstinence Education Program continued to provide abstinence-only education, health education activities at schools, and outreach activities at health fairs.

#### b. Current Activities

Community outreach activities impacted over 5,000 adolescents via public service announcements on television, radio youth talk shows, newsprint educational inserts, small to large group sessions, and one-on-one counseling at venues such as schools, colleges, community centers and churches. Peer counseling with an emphasis on postponement of sexual activity was provided in partnership with the University of the Virgin Islands Health Services Division and the Department of Education Life Skills Management educators and school counselors. The program played a pivotal role in several adolescent risk reduction initiatives for males and females ages 10-17.

***//2005/The significant decrease of 24% in 2003 versus 77% in 2002 is reflective in part to the services provided by Health Family Planning. In 2003, 688 adolescents received in-clinic services, 275 participated in interactive presentation on risk behavior topics, and 821 received preventative STDs tests. Other supportive services are provided by Childsworth, a local counseling, intervention and short-term residential care provider to adolescent females ages 13-17. Also, Women's Coalition and VICARE serves adolescent females with counseling, prevention and intervention on high risk situations encountered.//2005//***

#### 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 sexual involvement. Outreach staff will continue to provide sessions specifically for teens.

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

Orasure HIV testing will be expanded to St. Thomas. This testing began in July 2002 on St. Croix.

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

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

#### a. Last Year's Accomplishments

Level of Service: Population based

Population: Children

Data for this measure is not available.

Dental services available at the dental clinics administered by the Department of Health.

Services include: examinations, fluoride applications, fillings and extractions. Sealants are not offered due to lack of funding. The Medical Assistance Program does not cover this service for enrolled children.

## b. Current Activities

The Title V Program provided financial assistance for CSHCN requiring surgical or periodontal treatment that were not covered by the Medical Assistance Program.

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

## c. Plan for the Coming Year

The water supply in the Virgin Islands is not fluoridated. The use of sealants and fluoride has been proven to reduce or eliminate decay in the permanent teeth of children. Though this measure relates to a population-based preventive service, providing sealants will impact on direct care service dollars.

The memorandum of agreement with Community Health Dental Services to provide oral health services to all MCH & CSHCN clients will be revisited and revised. Funding will be allocated from the Title V Block Grant to assist with purchase of sealants and other supplies needed for these services.

Community partnerships will be established with pediatric dentists who have expressed a desire to assist the program in providing the spectrum of oral health services especially to the CSHCN population. These partnerships are anticipated to address community needs related to oral health and provide education to students, families, child care providers and other professionals related to maintaining healthy teeth, prevention of tooth decay and proper nutrition.

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

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

## a. Last Year's Accomplishments

Level of Service: Population based

Population: Children

These data are not currently available due to a vacancy for a Cause of Death Coder in the Vital Statistics Unit. There is not a Child Death Fatality Review Committee in the VI.

## b. Current Activities

There are no official reported deaths in this age group due to motor vehicle crashes.

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.

A public awareness and information campaign utilizing public service announcements and print media related to injury prevention is on-going.

The Division of Emergency Medical Services is located organizationally within the Department of Health. In addition, the Office of Highway Safety has on on-going media campaign regarding substance use (alcohol and other drugs) and driving.

The Vital Statistics Registry is unable to provide information due to lack of a Statistician and/or a Cause of Death Coder.

## c. Plan for the Coming Year

The program will continue to partner with VI-EMS in collaboration with the EMS-C Partnership Project to promote injury prevention and traffic safety activities in the community. School-based health center providers will be included in this partnership. Increase public awareness activities to include alcohol and other substance abuse safety issues as related to motor vehicle use.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

#### a. Last Year's Accomplishments

Level of Service: Population based

Population: Infants

The WIC Program is dedicated to the delivery of quality nutrition education and counseling, intervention, referral and follow-up on identified risks to improve low-income nutritionally at-risk, pregnant and breastfeeding women, infants and children.

Nutrition education is an important component of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) to help in improving the health and nutritional status of its target population. The broad goal of the VI WIC Program for fiscal year 2003 was, "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".

The primary focus this year was to provide intensive training to paraprofessional staff (nutrition aides) who provide clinic services to WIC participants in order that they may update and improve their competencies in providing nutrition education, nutrition assessment, eligibility and certification procedures.

Procured nutrition education and reference materials on various topics in maternal & child nutrition to include general nutrition, gestational diabetes, overweight, exercise, breastfeeding, nutrition during pregnancy, infant and childhood.

Planned and executed breastfeeding promotion campaign with a radio and television media blitz for World Breastfeeding Week 2003 and to continue throughout the month of August. The radio and television advertisements were developed by the Nutrition/Breastfeeding Coordinator and for the television, they were locally produced with help from the television staff. WIC moms and a dad were used in the campaign. Nutrition Education/Breastfeeding Coordinator was featured on local ABC Channel talking about breastfeeding and what WIC does to support breastfeeding participants. Feedback from clients asking about breastfeeding services and the community has been very significant.

Provided breastfeeding information to all prenatal clients at certification as well as individualized assistance to breastfeeding moms with problems.

302 breastfeeding mothers received breast bumps and other aides through WIC clinics and the Breastfeeding Counselors.

Nutrition Education/Breastfeeding Coordinator and Juan Luis Hospital Breastfeeding Counselor attended the La Leche League Annual Physician's and La Leche League's biennial International conferences in San Francisco July 1-6, 2003.

#### b. Current Activities

Breastfeeding is the preferred method of infant feeding for infants to support optimal growth. The VI WIC Program has been actively promoting, supporting and protecting breastfeeding for the past fifteen years and have seen significant increases in the percentage of postpartum women choosing to breastfeed.

Activities of the program this fiscal year were centered on the goal "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".

WIC continues to actively promote breastfeeding. Breastfeeding education is given to all pregnant participants. After birth, WIC health care providers give support and guidance to mothers who choose to breastfeed their infants in order that they may succeed.

Continued to provide a Breastfeeding Counselor for the Baby Friendly Hospital Initiative in the Roy L. Schneider Hospital, St. Thomas.

Provided breastfeeding discharge booklets and other breastfeeding materials to both community hospitals. These signed discharge booklets are used as baby identification for our newest WIC participants.

Provided breastfeeding information to all prenatal clients at certification as well as individualized assistance to breastfeeding women with problems.

Maintained breastfeeding rates at 86% in the Virgin Islands WIC Program.

WIC Clinics continue to support a positive breastfeeding environment where moms feel free to breastfeed their infants in WIC waiting rooms. So much so that women (WIC and non-WIC) shopping at the Sunny Isle Shopping Center feel free to come inside the WIC clinic to breastfeed.

Conducted mandatory training sessions for vendors, cashiers and WIC clinic staff to improve delivery of services to clients.

Provided 16 competency-based training session for clinic staff who deliver nutrition services in order to provide effective nutrition services.

Ensured WIC children completed their immunization schedule through age two.

### c. Plan for the Coming Year

The perception of breastmilk being inadequate for the total needs of the infant still persists. Efforts by VI WIC to continue its battle to dispel this belief is ongoing. Breastfeeding advertisements over the past two (2) years, have focused on promoting breastmilk alone as adequate to feed baby for the first six (6) months. While we have seen a decrease of 7% from last year in the percent of respondents stating that breastmilk is not enough, it is unknown what are all of the factors that may be contributory to that. VI WIC will persist however in its efforts to promote breastmilk as the optimum feeding for baby.

Promotion of breastfeeding through education about lactation and breastfeeding will continue to be given to all prenatal women and prenatal and post partum providers.

Breastfeeding support will continue to be available to postpartum women and the WIC Program will continue to encourage breastfeeding through group and individual education, nutritional support, dietary counseling, and distribution of breastfeeding aids to lactating women.

All WIC waiting room areas are "breastfeeding friendly."

Discharge surveys to breastfeeding mothers will continue to provide a mechanism to monitor breastfeeding rates.

Community and public awareness education activities using television, radio and print media to encourage breastfeeding.

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

### a. Last Year's Accomplishments

Level of Service: Population Based  
Population: Infants

The population-based service newborn hearing screening continued to function in partnership with the Infants and Toddlers Program. The MCH Audiologist on St. Croix performed auditory brainstem response tests (ABR). Patients from St. Thomas and St. John travel to St. Croix for follow-up testing and diagnostic evaluations, therefore eliminating the costs incurred for travel to Puerto Rico.

#### b. Current Activities

The addition of hearing screening technicians ensures increased availability of screening. Initial screening rates have increased significantly from forty (40) to ninety-six (96) percent (2004) territory wide since the inception of screening in 1999.

Guidelines and protocols for the EHDI Project were completed by the Advisory Committee. Program evaluation by National Center for Hearing Assessment and Management (NCHAM) was done. Both provider and parent satisfaction surveys were performed.

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.

A Memorandum of Agreement between the MCH & CSHCN Program and the Infants & Toddlers Program for provision of early intervention services for children identified and diagnosed with a permanent hearing loss is completed and submitted for approval. The purpose of this agreement is to clearly state the responsibilities of each agency in assuring that newborns are identified early for suspected or confirmed hearing loss and are receiving appropriate family centered intervention services.

#### c. Plan for the Coming Year

This will be the final year of funding from the CDC-EHDI Projects.

The Newborn Hearing Screening Program will continue using portable otoacoustic emissions equipment to test newborns at the two hospitals on St. Thomas and St. Croix. Newborns who need follow-up screening will be referred to the Infants and Toddlers (Early Intervention) Program. Brainstem audio-evoked response tests are conducted by the MCH and CSHCN Program audiologist on St. Croix.

Screening will be made available on St. John one day a week upon completion of the Morris F. deCastro Clinic, a Department of Health facility. This activity is intended to provide screening to infants who missed the hospital initial screening or need follow-up outpatient screening, or those who are home birthed. Based on demand, a hearing screening technician will be assigned on additional days.

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

#### a. Last Year's Accomplishments

Level of Service: Infrastructure Building  
Population: CSHCN

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 CHIP Programs, since there are such limited resources to offer these families.

## 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

## 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.

Families without health insurance will continue to be referred to the Medical Assistance Program to determine eligibility.

*Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

## a. Last Year's Accomplishments

Level of Service: Infrastructure Building

Population: Infants and Children

The MAP data system does not have the capability to generate specific claims data related to children and the services received.

The Medical Assistance Program (MAP) functions under a for fiscal year 2003 and 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, Family Planning, Nursing Home Services, Physician services that must be pre-authorized, and Dental services.

Optional services (but covered) are optometrist services, eyeglasses, prescribed drugs, air transportation, and respiratory therapy.

Optional services (not covered) are services in institutions for mental illness, hospital transfer/air ambulance transportation, dentures prosthetic devices, physical and occupational therapy, and/or durable equipment.

## b. Current Activities

CSHCN are disproportionately low-income, and because of this, they are at greater risk for being uninsured. Moreover, their needs for comprehensive, long-term health care are greater. MCH and CSHCN Programs will refer families to the MAP for eligibility determination. However, The Title V program continues to be the safety net for MAP eligible children who are unable to access services.

Translation services will continue to be available at clinics through bilingual staff. Translation is available for Spanish-speaking clients and for French dialects from the eastern Caribbean islands.

Transportation services are not routinely offered, but can be arranged. Off-island air transportation may be provided based on need and availability of funds.

Home visitation is provided on a priority basis for high-risk clients by MCH & CSHCN Program public health nurses.

### c. Plan for the Coming Year

The Title V program continues to be the safety net for MAP eligible children who are unable to access services otherwise.

All children registered in the program will continue to receive access to services regardless of third party insurance status or ability to pay.

## Performance Measure 15: *The percent of very low birth weight infants among all live births.*

### a. Last Year's Accomplishments

Risk factors associated with a high incidence of LBW babies are lack of prenatal care, alcohol and substance abuse, poor nutrition and infectious disease. The Virgin Islands Healthy Start Initiative, V. I. Perinatal Partnership (VIPP) focused on strengthening and enhancing the perinatal care systems in order to address the medical, behavioral and psychological needs of women and infants and to promote healthy births.

The VIPP Consortium and staff made great strides fiscal year 2003. There are more consumers represented and the training plan under the VIPP Consortium Leadership Institute was implemented.

Case management remains the core system, which centers upon individual assessment and creation of individual perinatal service plans. The plan is developed with the case manager and client and serves as a guide for clients as they navigate through the integrated system of perinatal care. Neighborhood outreach efforts to identify more women at risk for poor pregnancy outcomes. Services provided included health education and counseling, nutrition counseling, smoking and substance use cessation, in efforts to assure early and adequate prenatal care and improved birth outcomes.

### b. Current Activities

The infant mortality rate on St. Croix where the Healthy Start Program is based, remained at 1.3% of live births. Outreach and case management activities continue to identify women at risk and promote healthy lifestyles during pregnancy with the goal of improving birth outcomes and a reduction in low/very low birth weight infants.

### c. Plan for the Coming Year

Perform evaluation of VIPP to determine program effectiveness. The emphasis is on comparing stated objectives and performance standards with actual achievements of the program.

Assess accomplishments and performance data to determine whether the program's performance is as effective as established standards.

Continue to encourage and facilitate consumer awareness, knowledge and participation to foster healthy birth outcomes.

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

### a. Last Year's Accomplishments

Due to a vacancy in a coder position in the Vital Records Unit, no cause of death data is available.

## b. Current Activities

"Promoting Children's Mental Health Systems" was the focus of the V. I. Alliance for Primary Care Annual Meeting this year. Workgroups were formed to develop a comprehensive children's mental health plan for the territory including assessment tools for use in all clinic services.

Children and adolescents with SED needing multi-agency services will receive them in a coordinated fashion.

Adequate and appropriate crisis intervention and crisis stabilization services targeted for children and adolescents are a proposed component of the system, to avoid placement in adult facilities.

## c. Plan for the Coming Year

Continue work on comprehensive plan. Provide preventive educational material to school based health clinics.

Mental health services is a component of the school-based health centers to be implemented in school year 2003-2004 with the 330 health centers.

The Department will seek to fill a vacancy in a coder position in the Vital Records Unit in order to make cause of death data is available.

The MCH & CSHCN Program will continue collaboration with the Department of Education, Special Education Program, Children's Mental Health Task Force to assure information and referral sources for families of children requiring mental health assessment, management and treatment.

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

## 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, which is headed by a neonatologist. In 1999, a neonatologist was added to the staff of the Juan F. Luis Hospital on St. Croix. As a result, infants are no longer transferred from St. Croix to St. Thomas for Neonatal Intensive Care. 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.

The Territorial Perinatologist led the development of protocols for the treatment of high-risk prenatal patients.

## b. Current Activities

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

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

## c. Plan for the Coming Year

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

be continued.

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

**a. Last Year's Accomplishments**

The MCH Unit provides primary and preventative care to pregnant women, mothers and infants. Women are able to receive comprehensive reproductive health care. A major focus of the V.I. Perinatal Partnership Consortium is to enroll women in prenatal care early. (See discussion under Performance Measure 15.) The Perinatal Infant Coordination (PIC) Program offered case management and care coordination services to clients and outreached to public housing and low-income communities. 402 clients were served by V.I. Perinatal Partnership in 2003. Clients were provided counseling on health risk conditions, nutrition assistance via Health WIC Program, postpartum check ups at Health Family Planning, enabling services, i.e., transportation, laboratory, and Sonogram testing.

**b. Current Activities**

o See discussion under PM#15.

**c. Plan for the Coming Year**

Continue partnerships with programs that encourage early enrollment in early prenatal care, i.e. Family Planning, VIPP, Ryan White Title IV through outreach, education and awareness activities. Prenatal clinics will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Screen all infants for selected genetic / metabolic disorders.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Howard University Biochemical Genetics Lab provided screening on a contractual basis.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. 100% of children diagnosed with a sickle cell disorder are referred and				

enrolled in comprehensive medical care to ensure timely treatment and management.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Refer all children identified with significant hemoglobinopathy for Pediatric Hematology evaluation and diagnosis by 4 months of age.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Board certified Pediatric Hematologist continues to provide service on a contractual basis.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Development of an integrated newborn genetic-metabolic and hearing screening database for tracking and surveillance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Update and distribute newborn screening brochure to providers and parents.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Provide parent educational material.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Continue to work towards development of data linkage of newborn screening records and birth certificates.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10. Annual in-service/educational sessions for providers and parents.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				
1. Families are represented on the MCH Advisory Council. Involve families in task forces, advisory and planning committees.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Parent advocacy organizations are program partners and provide training, resources and services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continuation and strengthening of existing linkages and referral network.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Encourage family representation at the annual AMCHP meeting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Support opportunities for family members to attend local or national conferences, meetings and workshops.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Provide compensation for family participation in program activities, conferences, meetings.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Develop and administer exit surveys to determine satisfaction after clinic visits.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. Initial medical home training sponsored by the Infants & Toddlers Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Title V program functions as medical home for most CSHCN. All primary and specialty care is coordinated by public health nurses.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Convene as hoc committee to develop and implement a medical home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

model for cshcn and their families.				
4. Provide on-going education and presentations on the medical home initiative for program staff, partners and families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Educate families of cshcn of the importance of medical home .	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) 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)				
1. The Title V program provides access to specialty and sub-specialty services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Refer all families without insurance to Medical Assistance program to determine eligibility.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. Families are referred to appropriate community service agencies or organizations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Maintain and periodically update as needed a resource directory of all community-based services and organizations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Develop transition plan in collaboration with Vocational Education, Department of Education, adult health care services and other appropriate agencies.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide transition information to families.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Solicit and encourage family participation on transition planning ad hoc committee.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) 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.				
1. Assessment of immunization status included in each primary and preventive care visit.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue WIC immunization linkage.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Families are provided literature on AAP/CDC Guidelines on Immunizations.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17				

years.				
1. Provide and promote referrals to the Family Planning Program's adolescent health outreach services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Abstinence Education Program offers health education and promotion activities on abstinence as a healthy choice.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Promote use of protective sealants.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Screening and assessments for other dental conditions, preventive dental care and referral as appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Collaborate with WIC Program and Division of Dental Health Services to promote early start of good oral health practices.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Implement Memorandum of Understanding with Division of Dental Health Services to provide funding for protective sealants for 6-9 year olds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Collaborate with EMS and EMS-C programs to provide injury prevention educational activities related to traffic and motor vehicle passenger safety.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Encourage proper use of child passenger safety seats.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. The VI WIC actively promotes breastfeeding through community and public awareness education activities using television, radio and print media.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide literature on breastfeeding to prenatal and postpartum clients.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide lactation counselors (WIC Program)at both hospitals.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. All WIC waiting room areas are breastfeeding friendly.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Discharge surveys to breastfeeding mothers provide a mechanism to monitor breastfeeding rates.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Provide otoacoustic emissions screening for all newborns before hospital discharge or by one month of age.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide hearing screening technicians on a daily basis.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide literature on newborn hearing screening for prenatal providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Provide parent education literature on hearing screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Disseminate guidelines and standards for newborn hearing screening to all providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Develop a family resource guide for children identified with hearing loss. (See discussion under SPM #8).	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Complete integration of hearing screening database with newborn genetic/metabolic screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Merge screening data into one system to improve integrity for reports and analysis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Evaluate qualitative screening data to determine program efficiency in screening, identification of hearing loss and referral to early intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

services.

10.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

13) Percent of children without health insurance.

1. Refer all families without health insurance to the Medical Assistance Program to determine eligibility.

2. Document and provide data for children (number and percent) without health insurance enrolled and receiving services.

3.

4.

5.

6.

7.

8.

9.

10.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

1. Families are referred to determine eligibility for Medical Assistance (MAP).

2. Document and provide data for children (number and percent) who are receiving Medical Assistance services.

3. Use data obtained to compare ratio of children with MAP receiving services to children who are potentially eligible.

4. Provide EPSDT services for all children and adolescents receiving Medical Assistance.

5.

6.

7.

8.

9.

10.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

15) The percent of very low birth weight infants among all live births.

1. Perinatal protocols are finalized and operational in all prenatal clinic services.

2. Case management and outreach services provided by v.I. Perinatal Partnership.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Due to vacancy, cause of death information is not available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Referral to Division of Mental Health for risk assessment, evaluation and therapy when appropriate.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Collaborate with existing Mental Health Task Force to develop and implement a comprehensive children's mental health plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. There are no Level III nurseries in the Virgin Islands.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Prenatal clinics will perform appropriate risk assessment and encourage women to seek care for signs of early labor.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.					
1. Continue partnerships with programs that encourage early enrollment in early prenatal care.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of women who receive no prenatal care.*

a. Last Year's Accomplishments

The number of women who did not receive prenatal care in 2002 was 77. In 2001, 49 women did not receive prenatal care. Estimates are provided for 2003 as complete data is not available.

Prenatal services were provided in MCH Clinics, community health centers, family health centers and private clinics. The MCH Unit provides primary and preventative care to pregnant women, mothers and infants. Women are able to receive comprehensive reproductive health care. (See discussion under Performance Measure 18.)

A major focus of the V.I. Perinatal Partnership is to enroll women in prenatal care early and to keep them enrolled in care. (See discussion under Performance Measure 15.)

The Family Planning Program offers prenatal patients comprehensive, quality care and counseling and referrals are made to the MCH and Community Health Prenatal Clinics for full-term obstetrical / medical care.

b. Current Activities

See discussion under NPM 15 and 18.

c. Plan for the Coming Year

See discussion under NPM #15 and 18.

State Performance Measure 2: *The rate (per 1,000) of reported cases of HIV-positive mothers who received antiviral treatment to reduce perinatal transmission of HIV.*

#### a. Last Year's Accomplishments

The Virgin Islands has a high rate of AIDS cases with an incidence rate of 24.8% per 100,000 population, and HIV cases at 21.2% per 100,000 population. Black and Hispanic females ages 20-49 are at greatest risk of heterosexual infection. This measure was selected to address efforts for reduction of perinatal transmission of HIV. It also relates to the priority need for improving birth outcomes. Early identification and management with ART has been shown to significantly reduce transmission to newborns.

Of significance is that of 12 women reported to be HIV positive in 2003, none were reported by the Office of HIV/AIDS Surveillance Program to deliver HIV positive infants. It is unclear if any of these women were pregnant at any time during this period.

The Perinatal High Risk Clinic provides treatment and management to reduce the incidence of perinatal transmission.

Rapid testing is available in both hospitals Labor & Delivery units if documentation of HIV testing does not exist.

#### b. Current Activities

HIV testing is offered to all prenatal patients with pre and post counseling.

Ryan White IV Project provides access to coordinated, comprehensive clinical services and anti-retroviral treatment for HIV-positive pregnant women.

Access to medical care by a Perinatologist is provided.

Family counseling and partner testing and treatment are available.

#### c. Plan for the Coming Year

The MCH Unit will continue to provide primary and preventative care to pregnant women, mothers and infants. Women enrolled will receive comprehensive reproductive health care, including access to STD and HIV counseling and were encouraged to have periodic testing. Review existing policy regarding follow-up of pregnant women testing positive for HIV to ensure that all women are offered counseling and treatment options.

Continue partnerships with other programs, agencies and organizations that provide support services to families of women, children and adolescents identified as HIV positive.

Increase access to confidential HIV testing and counseling for women and adolescent youth.

The Family Planning Program will continue to provide OraSure (HIV) testing and referral services for HIV-positive women and adolescents.

Ryan White IV Project will continue to provide outreach, testing and counseling to the target population, women and adolescents of child-bearing age.

Outreach and education activities to the target population, women, children and adolescents, will continue in collaboration with Family Planning, VIPP, 330 Health Centers, MCH and Community Health Prenatal Services.

### State Performance Measure 3: *Percent of prenatal patients certified with the medical assistance program (MAP).*

#### a. Last Year's Accomplishments

Eighty (80) percent of clients at the MCH prenatal clinic had Medical Assistance (MAP) as their only insurance coverage. An average of forty (40) of those with appointments did not show up per clinic session.

The MCH Program facilitated enrollment of prenatal patients for Medicaid at all prenatal clinics. Eligible patients were referred to MAP for evaluation.

## b. Current Activities

Assistance in applying for Medicaid is provided to users of Title V services through social workers at the MCH & CSHCN facilities. Social workers inform clients of the necessary documents needed at the time of registration, i.e. birth certificates, passports, naturalization papers, etc.

In addition, information is provided about location of MAP offices, hours of operation, and how patients should apply for Medicaid.

MAP eligible patients are identified at a variety of sites including outpatient ambulatory facilities, hospital facilities, and other government agencies such as the Department of Human Services.

Patients who are low-income, uninsured, pregnant, or have special health care needs are referred to Social Services or the MAP offices directly for eligibility determination.

## c. Plan for the Coming Year

The MCH Program will refer all potentially eligible prenatal patients to MAP for eligibility determination.

## State Performance Measure 4: *Rate of asthma hospitalizations.*

### a. Last Year's Accomplishments

The MCH Program provided direct care and pediatric pulmonology consultation services for children with asthma. A monthly pulmonology Clinic provided comprehensive management, preventive and primary care, and educated parents on dealing with asthma and self-management.

MCH collaborated with the Asthma Partnership to develop a plan for community-based asthma education for children. The target population for this education campaign is elementary age children and their families. Prevention and education activities within the school system via school nurses, physical education and health teachers and coaches are the primary method for reaching this population. The program also provided resources and literature including videos on asthma triggers, posters on clearing the home of asthma triggers and indoor air quality for school personnel.

Additionally, a media campaign via print, TV and radio in collaboration with the St. Thomas Chapter, American Lung Association was utilized to reach the general community in efforts to raise awareness of asthma and available resources.

### b. Current Activities

In-service activity held in collaboration with the University of the Virgin Islands Cooperative Extension Service on St. Croix in December 2003. A previous session was held on St. Thomas in March 2003. In attendance were school nurses and other health care and school providers. Hospitalizations with asthma as the primary cause for admission were reported to be zero (0) for FY'03 in the 0-5 age group on St. Thomas. Data for St. Croix is not available.

### c. Plan for the Coming Year

Collaborative efforts with other health care providers, schools and child care providers will be strengthened and new partnerships developed to promote current treatment and management of asthma. This would provide opportunities for public health, schools and community organizations to develop an comprehensive asthma plan including an evaluation and surveillance system. The plan would address care coordination services for children with asthma and their families; diagnosis, treatment, and avoidance of asthma triggers, and

reduction of morbidity and mortality due to asthma.

Provide awareness and education programs for child care providers and early childhood school personnel to further knowledge of prevention, causes and risks.

Continue collaboration with the American Lung Association and the Department of Education to provide Indoor Air Quality for Schools-Managing Asthma in the School Environment training for all elementary school staff and nurses.

Provide educational material and literature to health care providers, community partners and families.

Seek funding to expand these activities to include a family / provider survey, morbidity and mortality data collection and analysis, and development of an adequate asthma surveillance system to monitor quality of care.

The MCH Program will continue to provide direct care and consultation services for children with asthma. A monthly Pulmonology Clinic is ongoing for the management of serious cases.

*State Performance Measure 5: Percent of livebirths to mothers who exceeded the maximum established weight gain during pregnancy.*

**a. Last Year's Accomplishments**

The MCH Program provided primary and preventative care for pregnant women; midwives assess prenatal patients and provided appropriate individualized counseling.

The program collaborated with the Bureau of Health Nutrition, WIC and the Bureau of Health Education to develop an educational program to address proper nutrition during pregnancy.

**b. Current Activities**

See discussion under NPM #15 and 18.

**c. Plan for the Coming Year**

No major changes in approach are anticipated. The MCH Program will continue to provide primary and preventative care for pregnant women.

Clinic certified nurse midwives will assess prenatal patients and provide appropriate individualized counseling.

Referrals for comprehensive care coordination and home outreach services will be made to VIPP.

The MCH Program will continue to collaborate with the Bureau of Health Nutrition, WIC and the Bureau of Health Education to develop an educational program to address proper nutrition during pregnancy.

*State Performance Measure 6: incidence of STD (not HIV) during pregnancy.*

**a. Last Year's Accomplishments**

The MCH Program provided counseling to adolescents relative to behaviors and practices that put them at risk for STDs. Counseling was coordinated with the STD Clinic, community health centers and the Family Planning Program.

Prenatal clients in whom an STD was suspected were referred to the STD Clinic for further testing and treatment.

The MCH Program collaborated with the STD and Family Planning Programs to increase the numbers of patients screened for STDs, including chlamydia.

b. Current Activities

See discussion under NPM #8, 15 and 18.

c. Plan for the Coming Year

The MCH and Family Planning Programs will provide counseling to adolescents relative to behaviors and practices that put them at risk for STDs. Consistent messages will be given by the STD Clinic, community health centers, Abstinence Education Program and the Family Planning Program.

Clients in whom an STD is suspected will be referred to the STD Clinic for further testing and treatment.

The MCH Program will continue to work with the STD and Family Planning Programs to increase the numbers of patients screened for STDs, including chlamydia.

Provide data collection methods for accurate reporting of STD incidence during pregnancy.

School based health services will provide STD testing, counseling and referral for treatment.

State Performance Measure 7: *The percent of teen mothers who received parenting skills training.*

a. Last Year's Accomplishments

The MCH Program identified community-based agencies and programs within the Department of Human Services providing parenting skills training to which DOH clients were referred.

b. Current Activities

Due to lack of funding, several community based organizations were unable to provide consistent parenting skills training. The Department of Education offers Life Skills which include parenting on the junior and senior high school level. The Family Planning Program includes parenting skills in the adolescent outreach services.

Department of Human Services provided parenting skills training to which DOH clients eligible for income assistance could be referred.

***/2005/ Information obtained from MCH, Community Health Centers, and Family Health Centers prenatal clinic services showed that parent empowerment classes are provided to approximately 250 parents annually in captive and voluntary audiences. Service providers include the Women's Coalition of St. Croix; Lutheran Social Services-Queen Louise Home for Children, St. Croix; The Village-V. I. Partners In Parenting-Parents As Teachers Program-Territorial; Family Resource Center, St. Thomas/St. John; University Cooperative Extension Service in conjunction with the V. I. Housing Authority-Territorial, and the V.I. Perinatal Partnership-A program of the Department of Health-MCH./2005//***

c. Plan for the Coming Year

School based health service providers will be encouraged to offer parenting skills training. This should be accomplished through partnerships with health educators, guidance counselors or individuals from other community-based organizations who provide family support services.

State Performance Measure 8: *Percent of infants diagnosed with hearing loss who are receiving appropriate early intervention services by age six months.*

a. Last Year's Accomplishments

The Early Hearing Detection & Intervention Project was funded by a CDC-Cooperative for a four year period beginning FY'01. The project strives to achieve the national standard of screening by one month, diagnostic evaluation by three months and enrollment into early intervention services by six months.

The availability of newborn screening technicians on daily basis including weekends and holidays has significantly increased the percent of infants who receive initial birth admission screening before discharge, and increased availability for outpatient rescreens.

An Advisory Committee was convened consisting of health care and early childhood providers, early intervention staff, community-based partners and family members. Brochures and developmental milestones posters are developed by the Resource and Education Workgroup. After review for completeness and cultural competency, they will be translated into Spanish and disseminated. A French Creole/Patois translation is being sought to assist with individuals who only speak this language. The National Center for Hearing Assessment & Management printed a limited number of brochures for dissemination.

A draft Memorandum of Agreement between the MCH & CSHCN Program and the Infants & Toddlers Program for provision of early intervention services for children identified and diagnosed with a permanent hearing loss is completed and submitted for approval. The purpose of this agreement is to clearly state the responsibilities of each agency in assuring that newborns are identified early for suspected or confirmed hearing loss and are receiving appropriate family centered intervention services.

Ninety-six (96) percent of newborns received initial hearing screening before discharge, up from forty (40) percent in 1999.

b. Current Activities

Medical home training was provided for MCH & CSHCN program staff by the University of Illinois at Chicago Division of Specialized Care for Children in January 2004. All MCH & CSHCN staff attended this training along with partners such as Birth to Three Program, Office of Special Education and community agencies. A medical home ad hoc committee was convened at the end of the training to plan, develop and implement a medical home model for the Virgin Islands.

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

The integrated newborn screening tracking and surveillance database was last modified and updated in July 2004. The database currently provides numbers for birth admission screening, follow-up outpatient screening and audiological diagnostic reports. Aggregate reports are also a feature of the database.

A program evaluator from the National Center for Hearing Assessment & Management (NCHAM) performed a review of the program using provider and parent satisfaction surveys and evaluating monthly reports.

c. Plan for the Coming Year

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

By the end of the project period the focus is to achieve full implementation with accurate

collection and reporting of data with a fully integrated database. Conversion of the database to SPSS is under consideration. This is anticipated to provide all the required statistical data and reports.

The final report for this year's NCHAM evaluation will assist in planning future project direction or changes required to accomplish the stated goals and objectives.

In the event that future funding is not available, a sustainability plan will have to be developed. Criteria and priorities for what could be realistically continued would be identified in order to best provide screening without additional funds.

Quarterly and annual reports will continue to be evaluated for areas that need improvement. This data will be shared with collaborating programs and providers.

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of women who receive no prenatal care.				
1. Outreach and case management efforts to promote healthy outcomes by V.I. Perinatal, Inc. will continue.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue partnerships with programs that encourage early enrollment in early prenatal care, i.e. Family Planning, VIPP, Ryan White Title IV through outreach, education and awareness activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The rate (per 1,000) of reported cases of HIV-positive mothers who received antiviral treatment to reduce perinatal transmission of HIV.				
1. The Perinatal High Risk Clinic will continue to provide treatment and management to reduce the incidence of perinatal transmission.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. HIV testing is offered to all prenatal patients with pre and post counseling.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Ryan White IV Project will provide access to coordinated, comprehensive clinical services and anti-retroviral treatment for HIV-positive pregnant women.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Increase access to confidential HIV testing and counseling for women and adolescent youth.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue partnerships with other programs, agencies and organizations				

that provide support services to families of women, children and adolescents identified as HIV positive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Percent of prenatal patients certified with the medical assistance program (MAP).				
1. The MCH Program will refer all potentially eligible prenatal patients to MAP for eligibility determination.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Patients who are low-income, uninsured, pregnant, or have special health care needs are referred to Social Services or the MAP offices directly for eligibility determination.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Rate of asthma hospitalizations.				
1. Develop a comprehensive asthma plan including an evaluation and surveillance system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide awareness and education programs for child care providers and early childhood school personnel to further knowledge of prevention, causes and risks.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide educational material and literature to health care providers, community partners and families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue to provide direct care and consultation services for children with asthma.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of livebirths to mothers who exceeded the maximum established weight gain during pregnancy.				
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) incidence of STD (not HIV) during pregnancy.				
1. Clients in whom an STD is suspected will be referred to the STD Clinic for further testing and treatment.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue to work with the STD and Family Planning Programs to increase the numbers of patients screened for STDs, including chlamydia.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. The MCH and Family Planning Programs will provide counseling to adolescents relative to behaviors and practices that put them at risk for STDs.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The percent of teen mothers who received parenting skills training.				
1. Establish partnerships with health educators, guidance counselors or individuals from other community-based organizations who provide family support services.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
8) Percent of infants diagnosed with hearing loss who are receiving appropriate early intervention services by age six months.					
1. Audiologists will perform diagnostic evaluation by 3 months of age to confirm permanent hearing loss (PHL).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2. Refer infant with hearing loss to early intervention services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3. Continue to monitor and track infants identified with PHL.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
4. Provide literature on permanent hearing loss to parents and providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### E. 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 determining 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.

### F. TECHNICAL ASSISTANCE

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

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

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 to be obtained.

See the complete Form 15 for the V.I. Technical Assistance request for FY 2003.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

#### Annual Budget and Budget Justification

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 MCH & CSHCN Block Grant was developed by the MCH & CSHCN Director and Program Administrator. 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 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 followed. (Please see Form 2, Form 3, Form 4, and Form 5).

### **B. BUDGET**

#### Annual Budget and Budget Justification

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.

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#### Completion of Budget Forms

The Virgin Islands Department of Health is budgeting a total of \$2,837,473 for FY2004. These funds are broken down as follows:

Amount Percent

Federal Title V \$1,621,336 55.9%

State \$1,216,060 44.1%

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 FY2004 federal Title V allocation, the earmarks are as follows:

Preventative and Primary Care for Children \$486,424(30%)

Federal Title V \$486,424 (30%)

## Title V Administrative Costs \$162,141 (10%)

Local matching funds include an additional \$100,000 for the leasing of clinic space on St. Thomas. Other federal funds amount to \$664,129 for the State Systems Development Initiative, Abstinence Education, Emergency Medical Services for Children, Ryan White Title IV and CDC Early Hearing Detection and Intervention. The MCH & CSHCN Program in the V.I. does not receive its program income. Clinic revenues are deposited into the Health Revolving Fund. The MCH Program does not collect program income.

Funds will pay for personnel costs attributable to program administration for the federally budgeted positions of MCH & CSHCN Director, Program Administrator and the Fiscal Officer. 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. Funds were budgeted to include a planned salary increase for unionized employees effective October 1, 2001.

### Direct and Enabling Services

Funds will be used to provide preventive and primary care to women of reproductive age and their infants up to one year of age, children, and youth. These funds will pay for employment of required medical and clinic staff, pay for needed services not directly being provided by the program, pay for specialty consultation not available in the territory, provide for equipment and supplies needed by the clinics, support outreach activities and technical assistance for developing a public awareness campaign. Funds will also be used to provide airplane travel for the Territorial Perinatologist to visit St. Croix on a weekly basis to provide clinical consultation and amniocentesis.

Funds will be used to provide or pay for services 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 for contractual costs to provide on-island specialty clinics in hematology, orthopedics, neurology, cardiology, Pulmonology, and off-island services such as endocrinology consults, radiologic diagnostic procedures, and electroencephalogram. Hearing aides, wheelchairs, and other assistive and orthotic devices will be purchased for patients. Funds will be used to pay for airline travel for the physical therapist to travel to St. Thomas on a bi-weekly basis to conduct two days of physical therapy services.

### Population Based Services

Funds will be used to pay the cost of contractual arrangement with Howard University to conduct the newborn screening; to conduct public awareness and informational projects; to fund staff for outreach programs; provide coordination and family support services; to pay for newborn hearing screening; and to pay for transportation costs for off-island patient care. Funds will be used to support the newborn hearing screening program primarily in the form of dedicated staff time to the project. Administrative costs for newborn screening will be the responsibility of the Early Hearing Detection, Intervention, Tracking & Integration Project.

### Infrastructure Building Services

Funding to support the annual meeting of the V.I. Alliance For Primary Care will be budgeted. Funds will be used to implement the Health Pro Software system in the MCH clinics and support the high speed data lines necessary to support the network and other adaptations for the purpose of data collections and data reporting.

### Other Requirements

#### 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 2003 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.

## **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.