U.S. Virgin Islands Supplemental Information Request Needs Assessment for the Maternal, Infant, and Early Childhood Home Visiting Program Maternal and Child Health Services

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CONTENTS

SECTION I: INTRODUCTION

The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) is anchored in research related to home visiting services. Specifically, MIECHV is a program that supports the provision of voluntary, evidence-based home visiting services to pregnant women and parents with young children (through kindergarten enrollment) deemed to be at-risk. The evidence-based program is anchored in substantial literature that has identified home visiting from key health and human services professionals as a protective factor against child abuse and neglect. Additionally, such home visits provide an opportunity to support positive parenting and improved maternal and child health, child development, and school readiness.

As a recipient of MIECHV funding, the VIDOH is mandated, under law to conduct needs assessments and needs assessment updates. The updated needs assessments provide the foundation upon which the MIECHV programs continue to build and ensure that program participants are receiving responsive, targeted, and appropriate services and supports.

Further, updated needs assessments inform strategic decision making and provide opportunities to engage key stakeholders as well as to expand and strengthen collaborations with a view to providing optimal services to program participants, paying particular attention to addressing gaps and high priority health needs delineated in the needs assessment.

BACKGROUND AND CONCEPTUAL FRAMEWORK

The Virgin Islands Department of Health and the Maternal and Child Health and Children with Special Health Care Needs Program (herein after, MCH & CSHCN Program) has served as the designated lead agency to advance the home visiting initiative in the USVI (USVI SIR Needs Assessment, 2011). The Territory received its first MIECHV grant in the fall of 2010, following the passage of March 2010 passage of the Patient Protection and Affordable Care Acts (USVI MIECHV, Final Report Narrative, 2018). The MIECHV Programs have been, from their inception, collaborative in nature. In the USVI, the MCH & CSHCN Program engaged in collaborative activities with several key agencies to ensure a solid foundation for the MIECHV Program in the Territory.

The identification of the MCH & CSHCN Program as the lead agency for the Territory's

MIECHV Program followed the amendment of Title V of the Social Security Act, adding Section 511, titled, Maternal, Infant, and Early Childhood Home Visiting Programs (MIECHV). The primary goal of the MIECHV Program is to strengthen and improve programs and activities that are a part of Title V. Further the MIECHV Program aims to improve coordination of services for at-risk communities, to find and to provide comprehensive services to improve outcomes for families who reside in at-risk communities.

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

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

The Maternal, Infant and Early Childhood Home Visiting Program

The Territory's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program operates under the umbrella of the MCH & CSHCN Program. The MIECHV Program is in its 10th year of operation in the Territory. The organizational chart below (Figure 1) provides a visual representation of the organizational structure of the MIECHV Program, from the identification of the administration of the program, which is carried out by a Program Manager, who reports to the Director of the MCH & CSHCN Program, to the clinical supervisory

personnel, the clinical field personnel and the administrative personnel who support the day-to-day operations of the program. The clinical staff are clearly identified by the district – St. Croix or St. Thomas-St. John (to include Water Island) – that they support.

A perusal of the organizational chart also reveals that there is an Advisory Committee that supports the MIECHV Program. The Advisory Committee is typically convened annually or bi-annually and members include the Director of the Territory's Medical Assistance Program, Director of Grants for the Community Foundation of the Virgin Islands, the Administrator of the Territory's Head Start Program, the Director of the Territory's Early Head Start Program, and other key stakeholders. Of note as one reviews the MIECHV organizational chart is that, as of September 2020, ***all program positions are currently filled***, though four of the filled positions (of a total of 10 funded positions) are new hires.

In the last two months, however, the MIECHV Program has lost two key staff members, as reflected in Figure 2 (page 8), an updated organizational chart (as of November 2020). The two positions currently vacant are the two of the four home visiting nursing positions. This has implications for optimal service delivery as will be addressed later in the discussion of program gaps around staffing.

Figure 1. USVI MIECHV Organizational Chart, September 2020

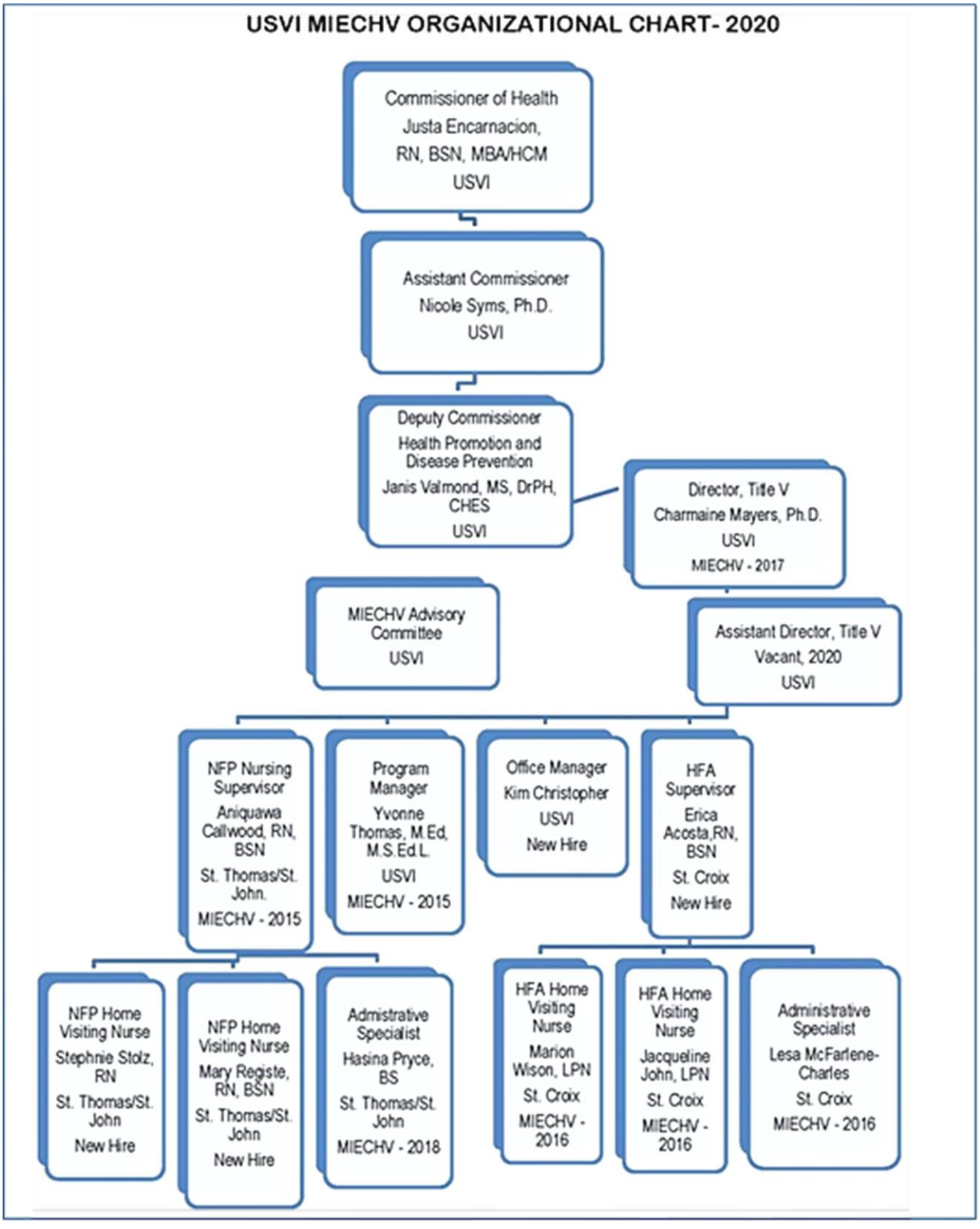
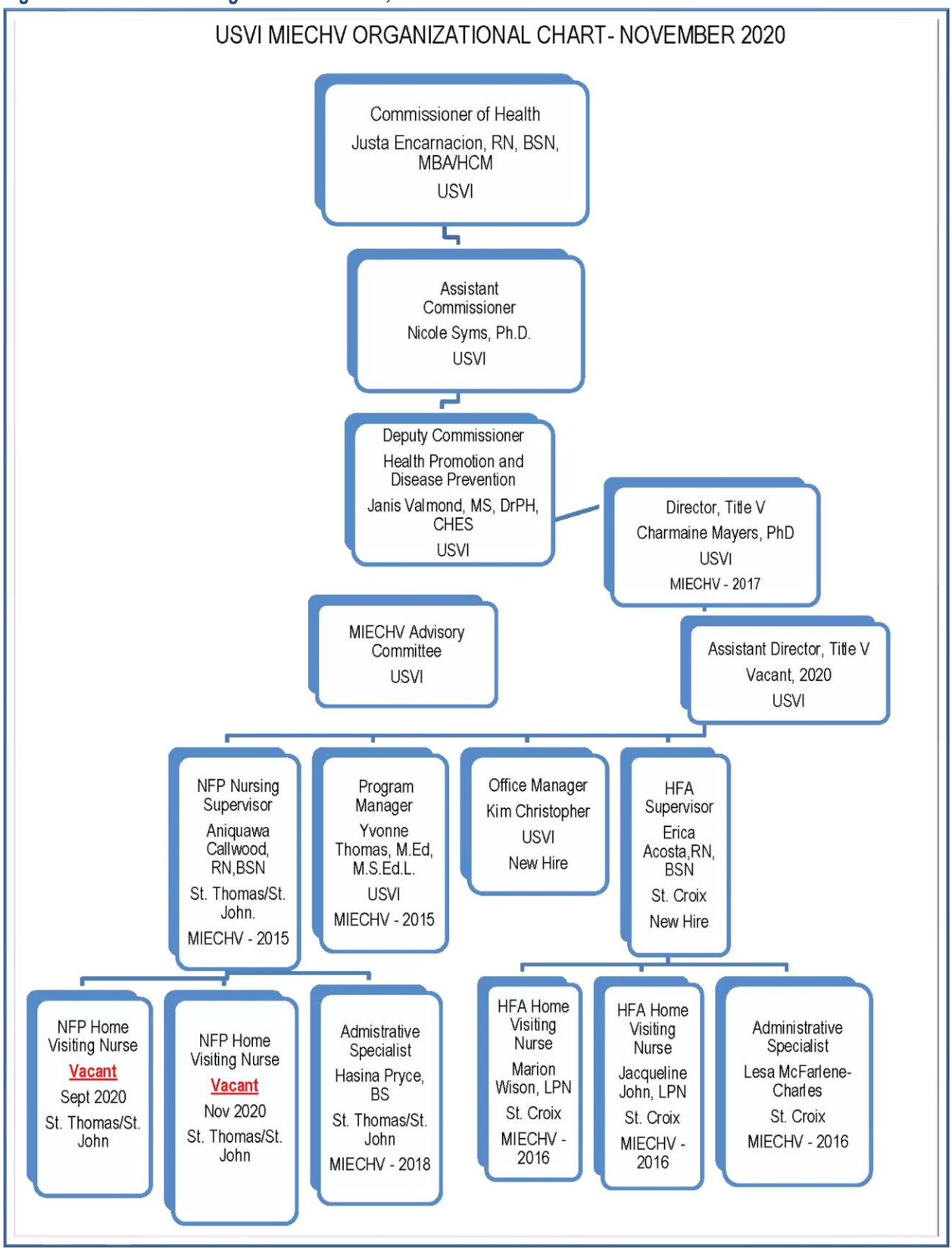


Figure 2. USVI MIECHV Organizational Chart, November 2020



The U.S. Virgin Islands Context

Geography and Relationship to the U.S.

The US Virgin Islands (USVI), a group of three main islands (St. Croix, St. Thomas [and Water Island], and St. John) and 50 smaller islets and cays is located on the edge of the Caribbean tectonic plate at the eastern edge of the Greater Antilles with the Atlantic Ocean to the north and the Caribbean Sea on the south. The USVI is 43 miles to the east of Puerto Rico and 1,100 miles from Miami on the US Mainland. The USVI, located along the Anegada Passage, is important as a key shipping lane for the Panama Canal. St. Thomas has one of the best natural, deep water harbors in the Caribbean (Figure 3).

Figure 3. Map of the U.S. Virgin Islands

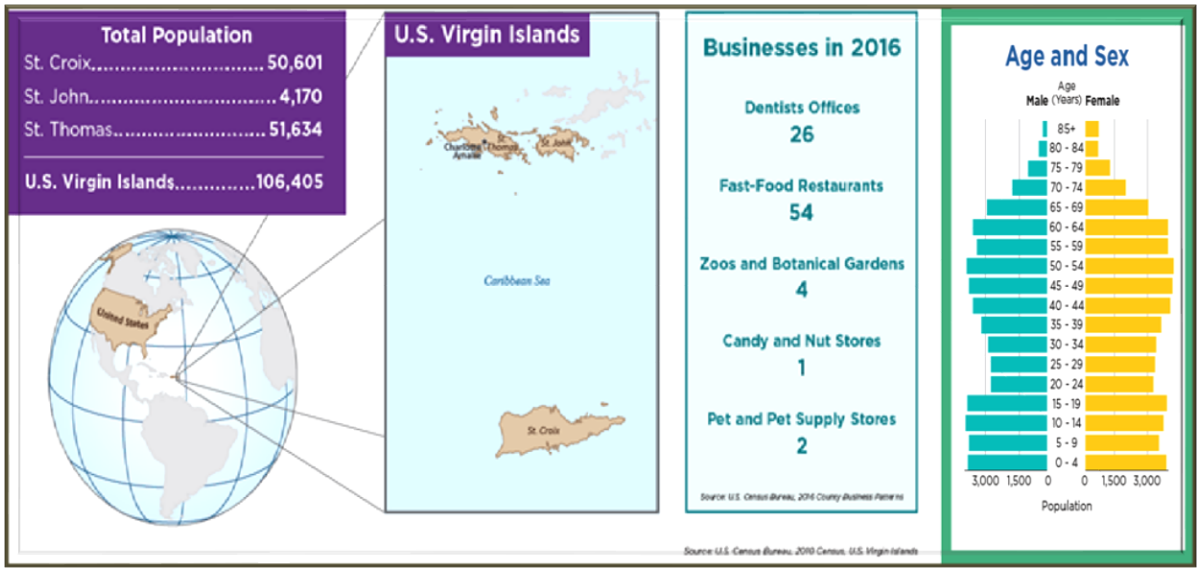
The Danes secured control over the southern Virgin Islands of St. Thomas, St. John, and St. Croix during the 17th and early 18th centuries when sugarcane, produced by African slave labor, drove the islands' economy during the 18th and early 19th centuries. In 1917, the US purchased the islands from Denmark, and the Virgin Islands became an unincorporated territory of the United States. Water Island was later designated the fourth island.

The policy relationship between the Virgin Islands and the federal government is under the jurisdiction of the Office of Insular Affairs, US Department of Interior. The July 1954 Organic Act of the Virgin Islands (revised 1962 and 2000) functions as the constitution for the Virgin Islands. Virgin Islanders are citizens of the US but do not vote in presidential elections. The Virgin Islands governor and lieutenant governor are directly elected on the same ballot by majority vote for a four-year term. The Legislature of the Virgin Islands is a unicameral body of fifteen senators (seven from St. Thomas, seven from St. Croix, and one at-large from St. John) who are elected by simple majority vote for a two-year term. One delegate to the US House of Representatives is elected by majority vote to serve a two-year term. The USVI representative can vote when serving on a committee and when the House meets as the Committee of the Whole House, but not when legislation is submitted for "full floor" House vote.

Selected Demographic Characteristics

The population estimate of 104,341(2020 worldpopulationreview.com) lives on 133 square miles mostly on St. Croix (84 sq. miles), St. Thomas-Water Island (32 sq. miles) and St. John (20 sq. Miles). The 2016 US Census Bureau population estimate prior to the 2017 hurricanes was 106,405 (See district breakdown in Figure 4).

Figure 4. USVI Geographic Location, Number of Selected Businesses and Population Pyramid



The Virgin Islands is a diverse community with residents with backgrounds from islands all over the Caribbean, US Mainland, Europe, and Asia. The official language is English with Spanish and French Creole also being prevalent in the community (FY 2020 Executive Budget, 2019). Seventy-six percent (76%) of the population are Afro-Caribbean

(black), while 15.6% are white, 1.4% are Asian and 2.1% are mixed or some other ethnicity. Hispanic or Latino of any race account for 17.4% of the population (10.3% Puerto Rican, 5.4% Dominican) based on 2020 estimates (https://worldpopulationreview.com). The average age is 44.5 years with the largest age group being from 45 to 64 years of age. Females outnumber males in each age category. The following figures are extracted from the 2015 VICS report. Figure 5 illustrates the USVI population by Territory, islands, and sex for the years 2014 vs 2015.

Figure 5. USVI Population by Island and Sex, 2014 and 2015

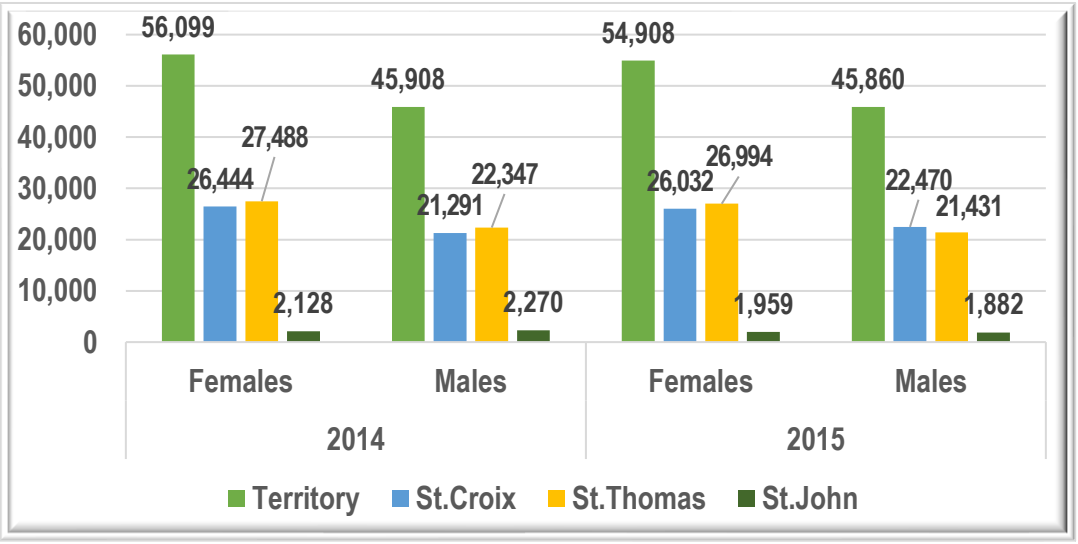
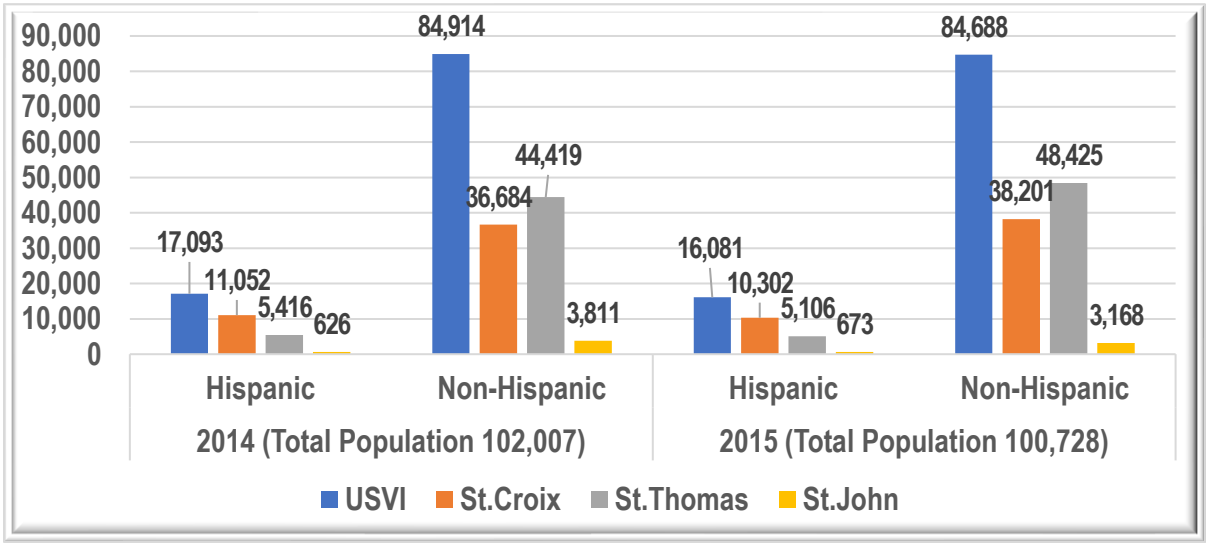


Figure 6, which presents the USVI population by ethnicity and islands, documents that most Hispanics reside on the island of St. Croix.

Figure 6. USVI Population by Island and Ethnicity, 2014 and 2015



The population of children 0-18 for the Territory and three main islands is presented in Figure 7 for years 1990 to 2015. This represents a gradual decline in the 0-18 population until 2010 when there was a slight increase followed by continued decline until 2015 when there was another slight increase (VIDOH Project LAUNCH). It should be noted that the population of Water Island is subsumed within the population counts for the island of St. Thomas.

Figure 7. USVI Child Population by Island, 1990 - 2015

	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2012	2013	2014	2015
Virgin Islands	35,427	34,289	34,480	32,517	33,269	31,656	30,917	28,786	27,903	27,335	25,523	27,026	24,869	21,471	18,238	19,730
St.Croix	18,706	18,169	18,053	17,420	17,131	16,176	15,768	15,043	14,785	14,796	12,862	14,031	12,815	11,179	9,675	10,079
St.Thomas	15,754	15,077	15,386	14,056	14,731	13,887	14,264	13,018	12,489	11,587	11,975	12,171	11,338	9,787	8,087	9,225
St.John	967	1,043	1,011	1,040	1,408	1,593	885	726	629	952	686	824	716	505	476	431

Table 1 provides information on the overall VI population and districts for children under five years by sex, race, and Hispanic origins for the year 2015.

Table 1. Age, Sex, and Hispanic Origin by District and Race, U.S. Virgin Islands, 2015

Age, Sex & Hispanic Origin	Virgin Islands				St. Croix				St. Thomas and St. John			
	Total	Black	White	Other	Total	Black	White	Other	Total	Black	White	Other
All Persons	**100,768**	80,559	11,672	8,537	**48,502**	38,143	4,016	6,343	**52,266**	42,416	7,656	2,194
Under 5 years	**5,241** (5.2%)	4,669	167	405	**2,674** (5.5%)	2,234	57	383	**2,567** (4.9%)	2,435	110	22
FEMALES	54,908	44,364	5,934	4,610	26,032	20,595	1,958	3,479	28,876	23,769	3,976	1,131
Under 5 years	**2,297** (4.2%)	2,095	55	147	**1,100** (4.2%)	925	28	147	**1,196** (4.1%)	1,170	26	-
HISPANIC	16,080	8,918	869	6,293	10,301	4,959	216	5,126	5,779	3,959	653	1,167
Under 5 years	**762** (4.7%)	499	55	209	**611** (5.9%)	397	28	186	**151** (2.6%)	102	26	22
FEMALES	9,464	5,592	541	3,331	6,108	3,295	77	2,736	3,355	2,297	464	595
Under 5 years	**353** (3.7%)	283	39	31	**280** (4.6%)	221	28	31	**73** (2.2%)	62	11	-

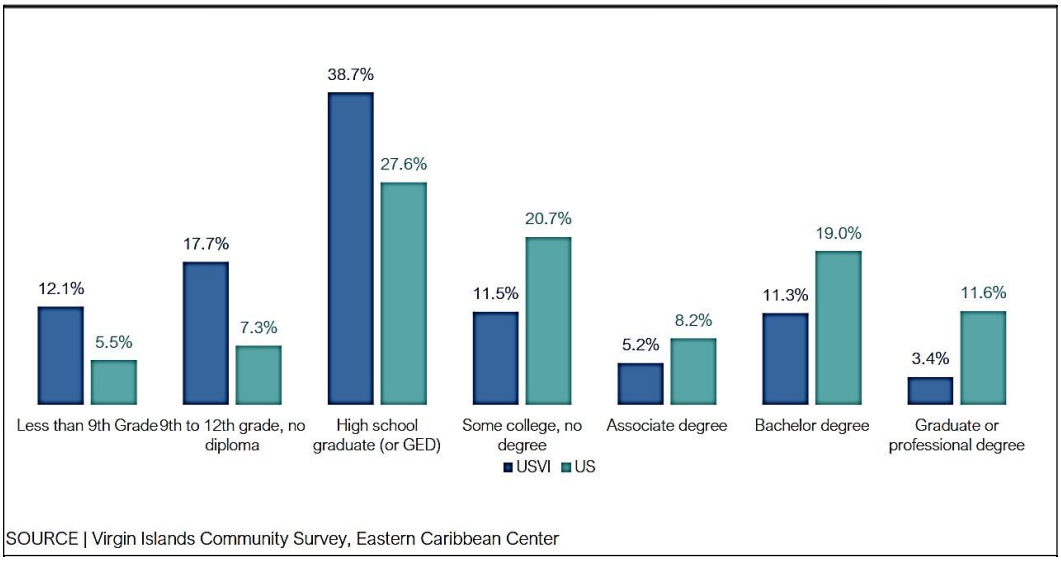
Selected Social Characteristics

Education and educational attainment

The St. Croix Foundation for community development June 2017, 20/20 Education Policy Steering Committee reported the following related to educational attainment. For the 2013-2014 school year, 41% of students ages 18-19 had not completed high school and in 2015-2016, 81% of VI public school students were not reading at level. The report further indicated that in 2015-2016, 93% of public-school students were not proficient in math and that since 2008, the number of incoming UVI freshman scoring below 500 points on the SAT steadily increased, spiking to 90% in 2015.

The Virgin Islands Community Survey reports on educational attainment of adults providing the number of persons and the percentage in each category of the total population in that age group (Figure 8). 70.1% of this age group had a high school or higher level of education.

Figure 8. Percent of USVI Adults by Educational Attainment, 2015



Immigration and Primary Language Spoken at Home

Of the 26,799 naturalized citizens reported in the 2013 VICS, immigrants came primarily from the Caribbean Islands of Antigua and Barbuda, the British Virgin Islands, Dominica, the Dominican Republic, St. Kitts and Nevis, and St. Lucia, with 4,052 from elsewhere. For those who speak other languages than English at home, the primary language most spoken is Spanish followed by French Patois, Creole, and other languages. Employment is documented as the primary reason for entry into the Virgin Islands, including being a spouse of the

employed person, a dependent of the employed person, or a family member of the employed resident. The next most reason for entry was for a student to attending college.

Selected Economic Characteristics

The Virgin Islands Department of Labor estimated that the mean annual wage for all occupations in the Virgin Islands in 2019 was $45,970. This compares to the U.S. mean wage of $53,490 during the same period (US Bureau of Labor Statistics). The estimated VI entry level annual wage was $25,320 and the experienced annual wage was $54,690. The average number of persons employed in 2019 was 34,420.

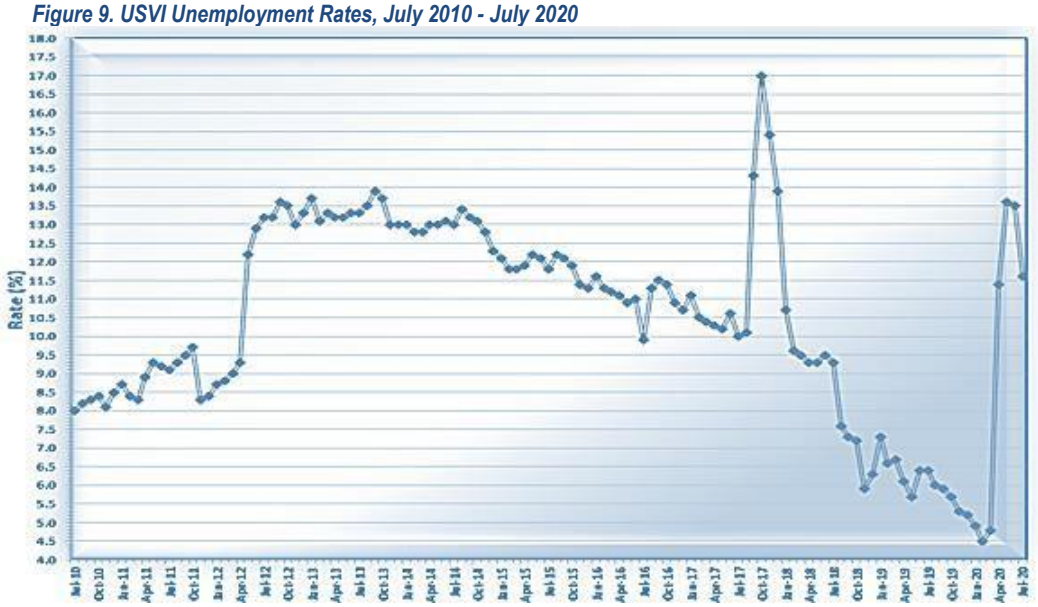
Based on information from the Virgin Islands Department of Labor (Table 2 and Figure 8), the number of persons employed during 2020 has declined from 43,109 in January to 40,938 in July. Unemployment rates have fluctuated widely between July 2010 and July 2020, with the highest rate of 17% unemployment occurring in October 2017 after the two category 5 hurricanes ravaged the islands in September 2017 causing widespread devastation. Since October 2017 there was a steady decline in unemployment to a low of 4.5% in January 2020, before the pandemic, after which unemployment rates increased to a high of 13.5% in April 2020. While the unemployment rate has decreased since April 2020, these statistics underscore the Territory' economic vulnerability to natural and other disasters that negatively impact its primary tourist industry and economic stability.

Table 2. USVI Labor Force Estimates, January - July 2020

2020 Virgin Islands Labor Force Estimates								
		Jan	Feb	Mar	Apr	May	Jun	Jul
Virgin Islands	Labor Force	45,331	45,699	45,803	45,719	47,538	47,086	46,304
	Employment	43,109	43,621	43,609	40,484	41,059	40,734	40,934
	Unemployment	2,222	2,078	2,195	5,235	6,479	6,352	5,370
	Unemployment Rate	4.9	4.5	4.8	11.4	13.6	13.5	11.6
St. Croix	Labor Force	20,140	20,551	20,624	20,005	20,917	20,782	20,841
	Employment	19,131	19,597	19,579	18,240	18,638	18,469	18,797
	Unemployment	1,009	954	1,045	1,764	2,279	2,313	2,043
	Unemployment Rate	5.0	4.6	5.1	8.8	10.9	11.1	9.8
St. Thomas/ St. John	Labor Force	25,191	25,148	25,180	25,714	26,622	26,304	25,464
	Employment	23,978	24,025	24,030	22,244	22,421	22,265	22,137
	Unemployment	1,213	1,123	1,150	3,470	4,201	4,039	3,327
	Unemployment Rate	4.8	4.5	4.6	13.5	15.8	15.4	13.1

Source: HTTPs://www.vidolviews.org

Figure 9. USVI Unemployment Rates, July 2010 - July 2020



Source: HTTPs://www.vidolviews.org

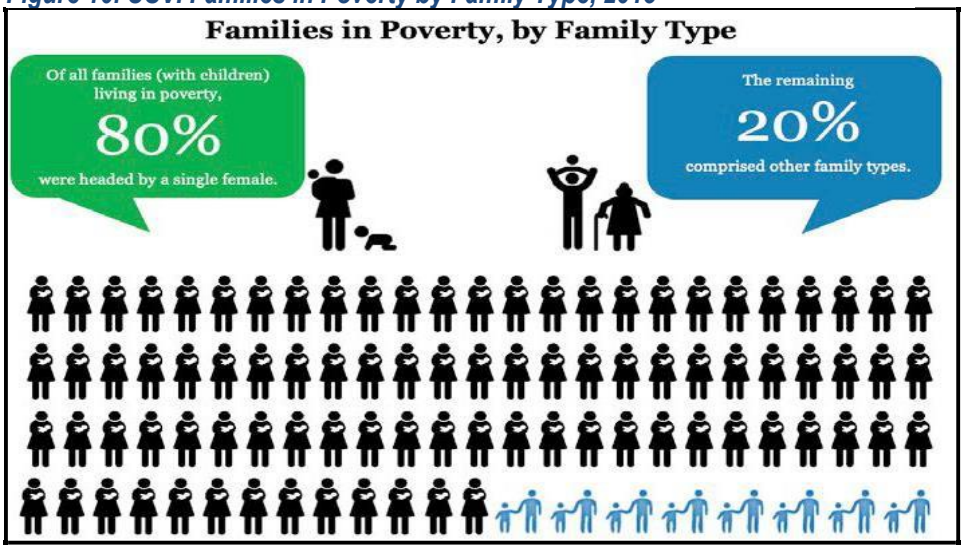
The 2020 Federal employees cost of living allowance (COLA) for the Virgin Islands is 12.62% (https://www.erieri.com/cost-of-living/united-states/virgin-islands). The Kaiser Family Foundation (KFF) 2017 U.S. Virgin Islands: Fast Facts documented the Virgin Islands overall poverty rate as 20% compared to 14% for the U.S.

Status of Children and Families in the US Virgin Islands

The 2019 USVI Kids Count Data Book reported that in 2015, 23.4% of VI children (4,607) lived in married-couple families compared to 66% of US children who lived in married-couple families. In 2015, 58% of children lived with a female parent only, while 8.2% of children lived in a household headed by an adult other than their parent – most often a grandparent.

The Kids Count Data Book reported 30% of Virgin Islands children were living in poverty as compared to the 13.5% of U.S. children living in poverty. For Black families with children in the VI, 26.8% were living below the poverty level, while among White families with children, 6.4% were living below the poverty level and, among Other Race families with children, 22.6% were living below the poverty level. Children living in poverty were more likely to live in a one parent, female-headed home (Figure 10).

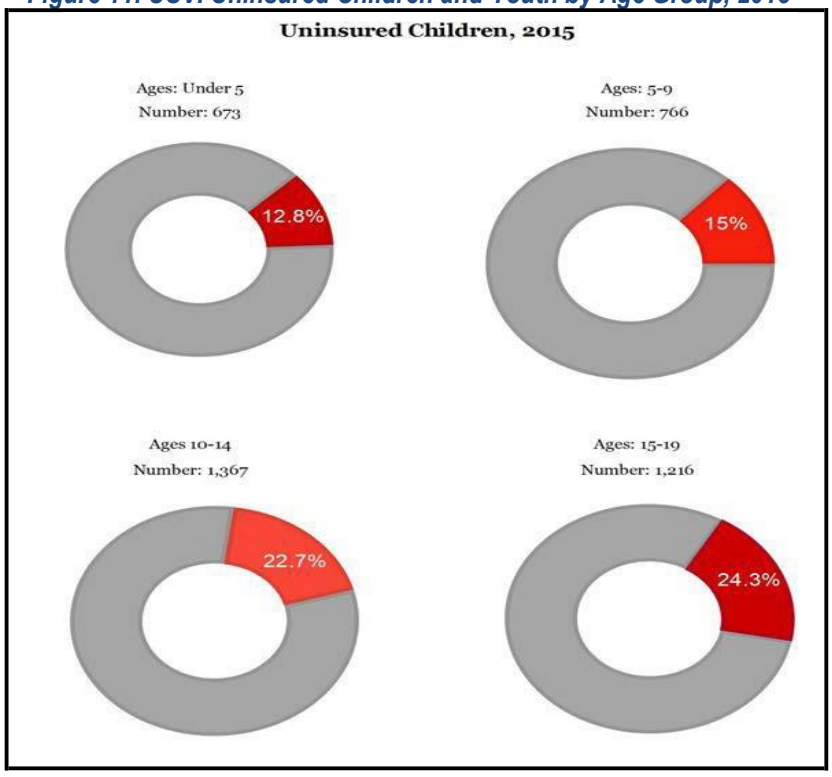
Figure 10. USVI Families in Poverty by Family Type, 2015



Source: USVI 2019 Kids Count

Poverty and the lack of family health insurance also negatively impacts children. Kids Count reports that in 2015, 18.9% of all VI children and youth, ages birth through 19 (4,022 children) lacked health insurance and 12.8% of VI children under age 5 were uninsured (Figure 11).

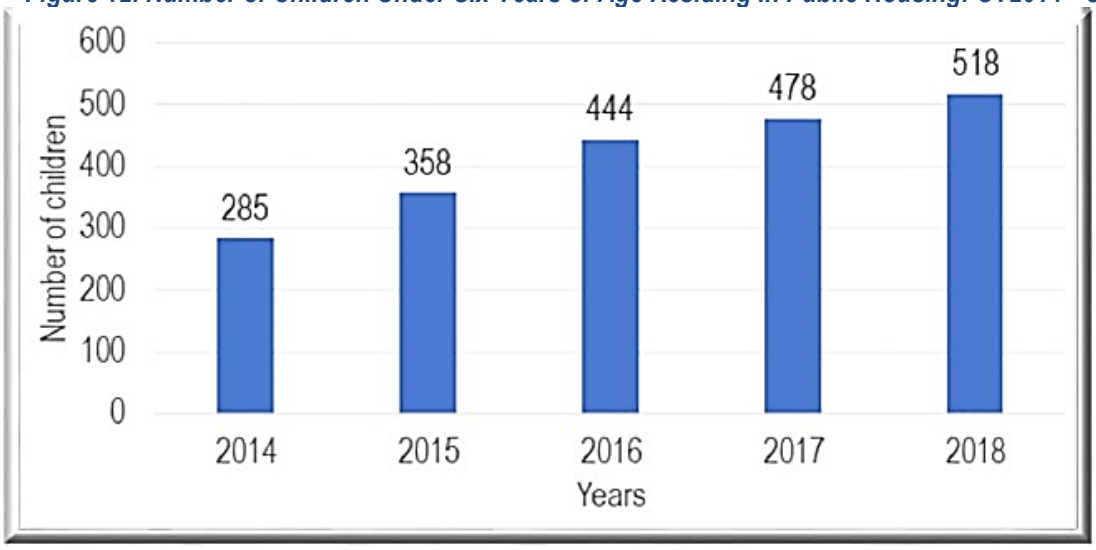
Figure 11. USVI Uninsured Children and Youth by Age Group, 2015



Source: USVI 2019 Kids Count

As reported in the 2020 USVI'S ECE Mixed-Delivery System needs assessment, "Children and their families, in the Territory, are frequently enrolled in multiple programs for services managed by the Departments of Education, Health, Agriculture and Human Services. Programs for children birth through five (B-5) include Early Head Start (EHS), Head Start (HS), Maternal and Child Health and Children with Special Health Care Needs (MCH & CSHCN), Infants and Toddlers (Part C), Women, Infants and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) childcare subsidies and Medical Assistance Program (MAP) among others (p. 13)". In addition, the increasing number of children residing in public housing can serve as an indicator of families in need of support services (Figure 12).

Figure 12. Number of Children Under Six Years of Age Residing in Public Housing: CY2014 - CY2018



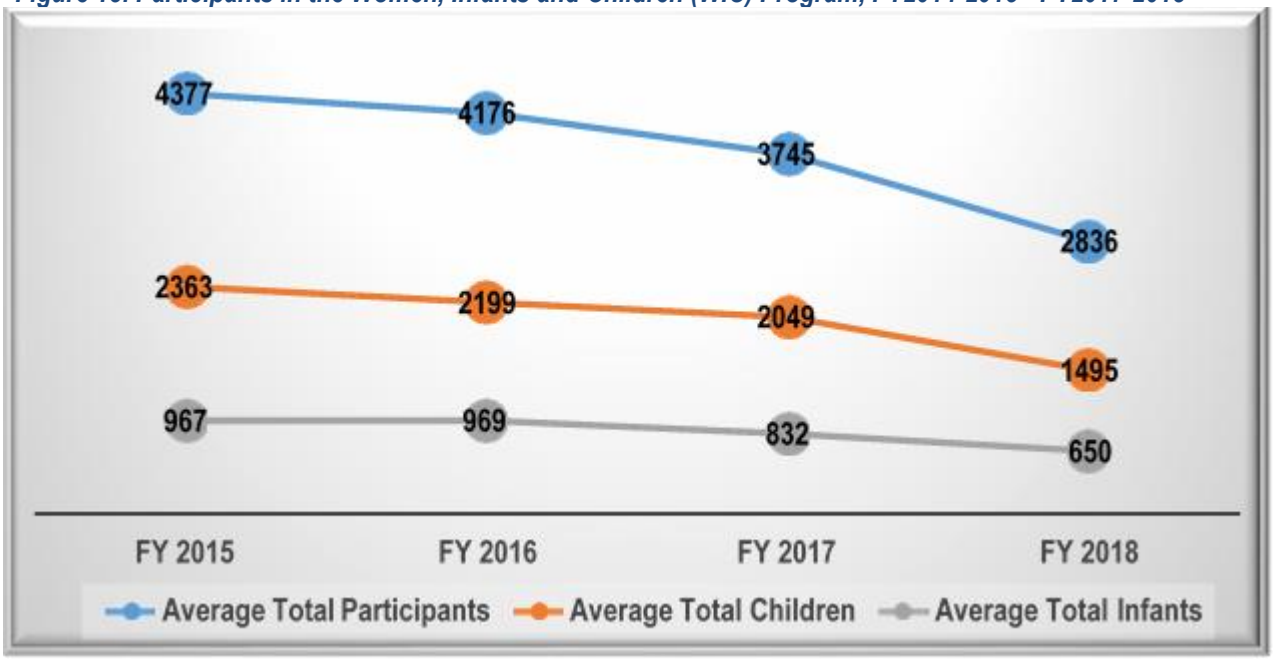
Source: 2020 USVI Early Childhood Care and Education Needs Assessment

The WIC program provides supplemental foods and nutrition education at no cost and referrals to other health care and social services programs and agencies. Its participants are eligible pregnant, breastfeeding, and non-breastfeeding postpartum women, infants, and children up to age five. Research has found that WIC participation improves the nutrition and health outcome for low income families as participants have been shown to have more nutritious diets, better health care for children.

The USVI WIC Program (herein after, VI WIC) maintains the highest breastfeeding rate in the Mid-Atlantic Region and continues to be among the top 10 for highest breastfeeding rates in the nation, for which VI WIC has received breastfeeding monetary bonus awards in FY 2010 and FY 2018 from the USDA Secretary of Agriculture. Figure 13, below, provides VI

WIC participation numbers for FY2014-2015 through FY2017-2018 and reveals that the average number of participants in the program has trended down for each fiscal year and for both children and infants. FY2015 had the highest number of participants, while FY2018 had the lowest average number of total children participants as well as total infant participants. This trend aligns with the continuing decline in the overall birth rate in the Territory over the past decade.

Figure 13. Participants in the Women, Infants and Children (WIC) Program, FY2014-2015 - FY2017-2018

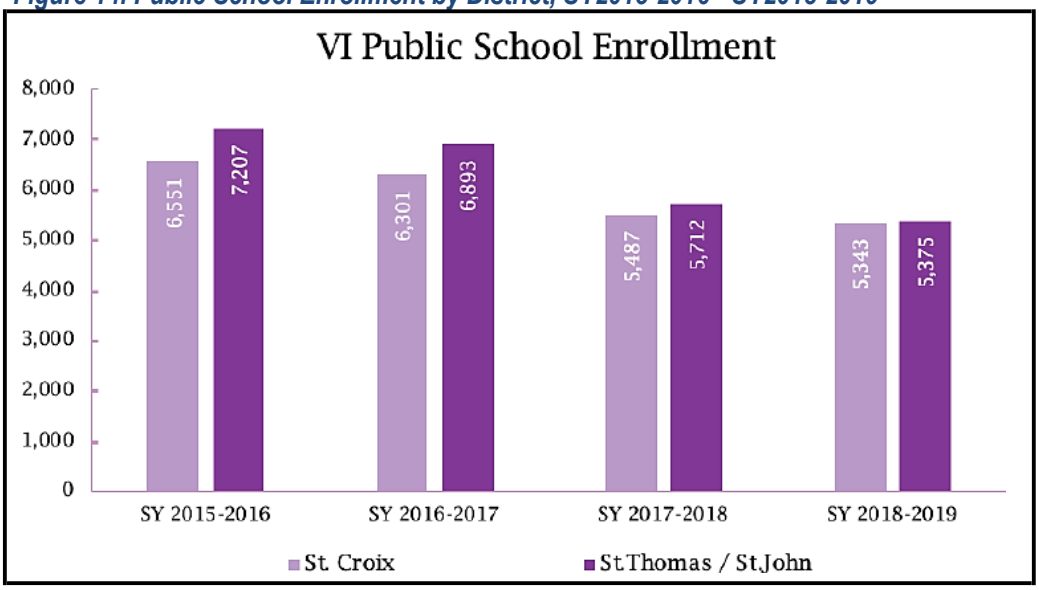


Source: 2020 USVI Early Childhood Care and Education Needs Assessment

There was a reduction in public school enrollment between the 2015-2016 school year and the 2018-2019 school year (Figure 14). Some of the attrition can be attributed to transfers to schools outside the Virgin Islands, transfers to a non-public school in the Territory or student enrollment in Adult Education, a Skills Center, or the Job Corps. However, between school year 2016 and 2017 the number of dropouts doubled from 246 to 482. Within the 2017-2018 school year, most reported dropouts were from the St. Thomas/St. John school district (80%, or 383 students) (Figure 15).

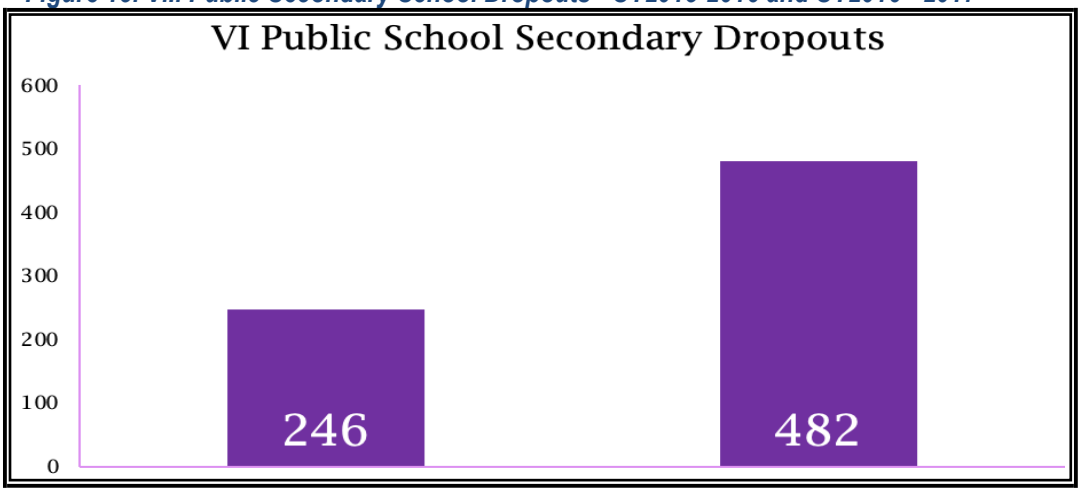
Kids Count reported that for the 2017-2018 school year, 654 of 1,050 students graduated from high school (62.3%), which was a decrease in the 4-year cohort graduation rate of over 10 percentage points, from the previous year (72.7% in SY 2016-2017). Nine percent (9% - 59 students) graduated with a disability, and 4.4% (29 students) graduated with limited English proficiency.

Figure 14. Public School Enrollment by District, SY2015-2016 - SY2018-2019



Source: USVI 2019 Kids Count

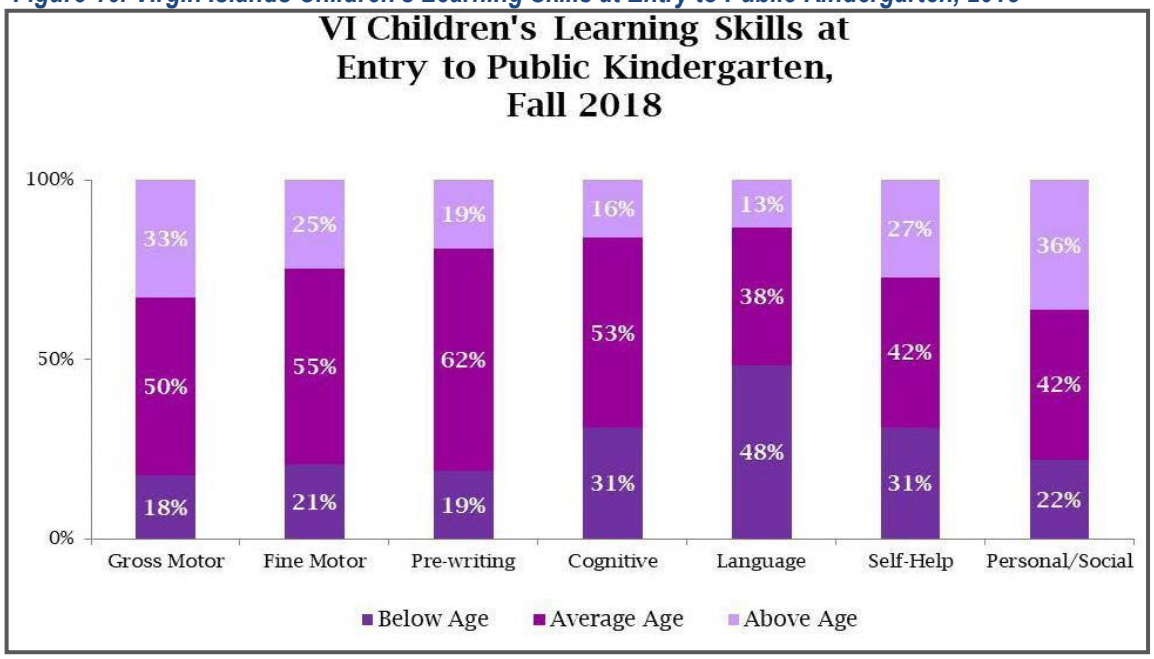
Figure 15. V.I. Public Secondary School Dropouts - SY2015-2016 and SY2016 - 2017



Source: USVI 2019 Kids Count

Based on Children's Readiness for School LAP-3 Data, Virgin Islands children transitioning from preschool to kindergarten in 2018 underperformed in the areas of cognitive, language and self-help with over 31% lacking these skills (Figure 16). Their best performances were in the areas of gross motor and personal/social skills.

Figure 16. Virgin Islands Children's Learning Skills at Entry to Public Kindergarten, 2018



Source: USVI 2019 Kids Count

Child abuse is a main reason for children placement in foster care. Table 3 presents the primary types of abuse of Virgin Islands children in the years reported by the national Kids Count Data Center.

Table 3. USVI Child Abuse Number and Rate by Type of Abuse, 2007 - 2018

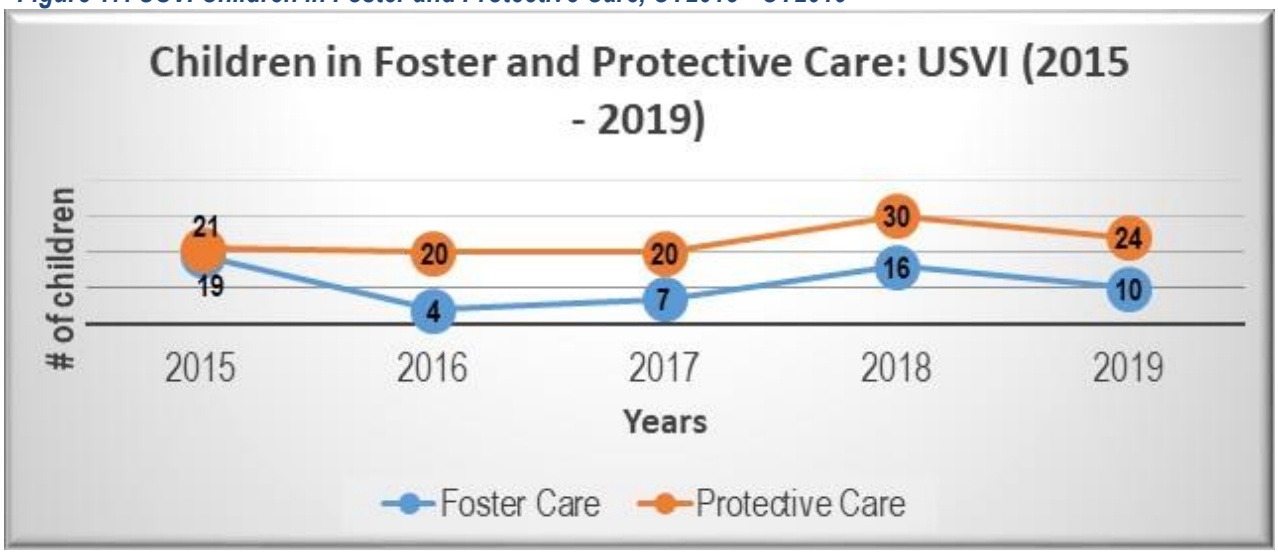
Type of Abuse	Data Type	2007	2008	2013	2014	2015	2016	2017	2018
Neglect	Number	208	142	160	50	91	120	109	154
	Rate per 1,000 population 0-18	7.5	5.2	7.5	2.7	NA	NA	NA	NA
Physical Abuse	Number	84	31	100	52	102	162	112	58
	Rate per 1,000 population 0-18	3.0	1.1	4.7	2.9	NA	NA	NA	NA
Sexual Abuse	Number	69	61	65	33	25	33	39	22
	Rate per 1,000 population 0-18	2.5	2.2	3.0	1.8	NA	NA	NA	NA

Source: https://datacenter.kidscount.org/data/tables/5364-child-maltreatment-by-type

The Virgin Islands Department of Human Services reported a 47% decline in the number of children in foster care, in the Territory, between 2015 and 2019. While there was a doubling of the number of children in foster care in 2018, from 2017, after the passage of hurricanes Irma and Maria, the number has started to trend downwards again in 2019. In a

similar vein, the number of children in protective care remained constant between 2015 to 2017, however, there was a fifty percent increase in the number children in protective care in 2018, from 2017 (Figure 17).

Figure 17. USVI Children in Foster and Protective Care, CY2015 - CY2019



SECTION II: COMMUNITIES WITH CONCENTRATIONS OF RISK

To provide responsive and timely healthcare services, it is important that program personnel and service providers have a clear understanding the composition of communities across the Territory, but particularly of communities with concentrations of risk. This section of the CHNA supports and expands this understanding by providing data either extending the information provided by the indicators used in the simplified method to determine communities with concentrations of risk in the USVI broadly, and each district, more particularly, or adding to the indicators used to determine geographic areas with concentrations of risk.

DATA ADDED TO SIMPLIFIED METHOD

As noted in the description of the Simplified Method for identifying communities with concentrations of risk to be able identify target communities for home visiting programs, indicators for the Territory were selected based on factors such as availability and reliability of indicators at the district level (St. Croix and St. Thomas-St. John) as well as whether identified indicators aligned with criteria for identifying target communities for participation in the MIECHV Program. The indicators selected reflect five domains, namely, socio-economic status (SES), adverse perinatal outcomes, substance use disorder, crime, and child maltreatment.

HRSA worked with USVI MIECHV staff and Title V staff to identify and obtain raw data and to develop formulae for generating descriptive statistics, raw indicators, standardized indicators, and establishing at-risk domains. For the SES domain, specific indicators included in the simplified method are poverty, unemployment, and HS Dropout. For the perinatal outcomes domain, indicators are preterm birth and low birth weight (LBW); for the substance abuse domain, indicators are alcohol, marijuana, cocaine, and pain relievers. For the crime domain, indicators are crime reports (prevalence) and juvenile arrests. Finally, for the child maltreatment domain, the indicator is child maltreatment.

In implementing the simplified method, most of the data identified and included were sourced from the 2015 Virgin Islands Community Survey. Data for the domains child maltreatment and crime (juvenile arrests) were sourced from USVI Kids Count Data books. Data for the substance abuse domain were sourced from the Territory's 2016 BRFSS data. Though potential data sources were identified for possible retrieval of data for specific

indicators to support the five domains linked to communities being identified as “at risk”, the data sources did not always yield data on the indicators previously delineated.

Description of Data Added

Given that data were not available for all indicators in each of the five domains, there was a determination made with the MIECHV administrative personnel and the team completing the needs assessment, that additional data should be included to help inform the determination of communities with concentrations of risk. Since the Territory is divided into two districts – St. Croix and St. Thomas-St. John, the identified indicators and data on hand were used to establish each district as a community ‘at risk’. Based on available data for the SES and crime domains, both districts meet the criteria for designation as at-risk geographic locations and thus it is appropriate that home visiting programs are being implemented in each district.

Yet, though the at-risk designations have been satisfied based on the Simplified Method, in this section of the needs assessment, data are provided for some indicators and expanded data are provided for others. First, for data in support of adverse perinatal outcomes domain, data will be presented to document preterm deliveries, LBW, and VLBW babies for CY2015 – CY2018. This will provide an added dimension not included in the Simplified Method, since no data for this domain was included. Additionally, for the SES domain, more expansive data will be provided on the dropout indicator, to include dropout data for junior high school students by district, senior high school students, by district, and broadly, dropout rates by grade level, Territory-wide.

Additional added data include data in support of the substance abuse domain, specifically sourced from the Territory’s BRFSS 2016 results, and the child maltreatment domain. A final area of added data relate to the number of children, ages 3 – 5 receiving special education supports, as documented in Child Find reports that the Territory’s State Office of Special Education (SOSE) must report annually to the Office of Special Education Programs (OSEP) at the U.S. Department of Education.

Description of Methodology

Data added were secured from existing administrative data generated by various entities, the Virgin Islands Community Survey and other surveys, or other secondary sources and published reports. For administrative reports generated by key government agencies,

requests were made to data personnel or program directors to share information. The purpose and use of the data, to support this needs assessment, was shared. None of the data shared included Personally Identifiable Information (PII) or other personal information that would result in any individual being identified or tracked.

PROCESS USED FOR IDENTIFICATION OF 'AT-RISK' COMMUNITIES

As noted above, based on the simplified method, both the St. Croix and St. Thomas-St. John Districts met the criteria for designation of "at risk" communities, having a greater than zero score on at least two of the five domains (*See MIECHV USVI Summary Excel Workbook.*). Additionally, other data from surveys conducted provided data for some of the domains which provided additional support to identify "at risk" communities in the USVI.

Indicators of At-Risk Prenatal, Maternal, Newborn, Or Child

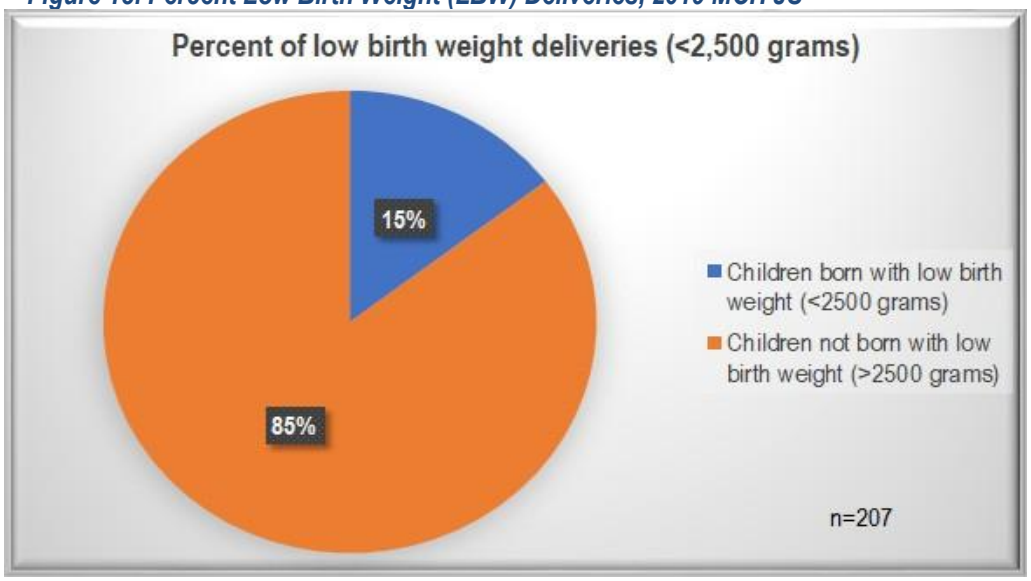
Premature Births

Based on data collected by the MCH and CSHCN Program nursing staff, there were premature births in both the St. Croix and St. Thomas-St. John Districts during calendar years 2016 through 2018. For the Territory, the rate of premature births per 1,000 live births ranged from a low of 73.7 in 2016 to a high of 111.7 in 2018. Similar patterns were observed with respect to LBW and VLBW for the districts and Territory between 2016 and 2018, with higher LBW rates per 1,000 live births in 2018 than in 2016 or 2017. Of note is that the VLBW rates were consistently lower across both districts and the Territory than the LBW rates per 1,000 live births.

Low birth-weight infants JMCH/NORC data

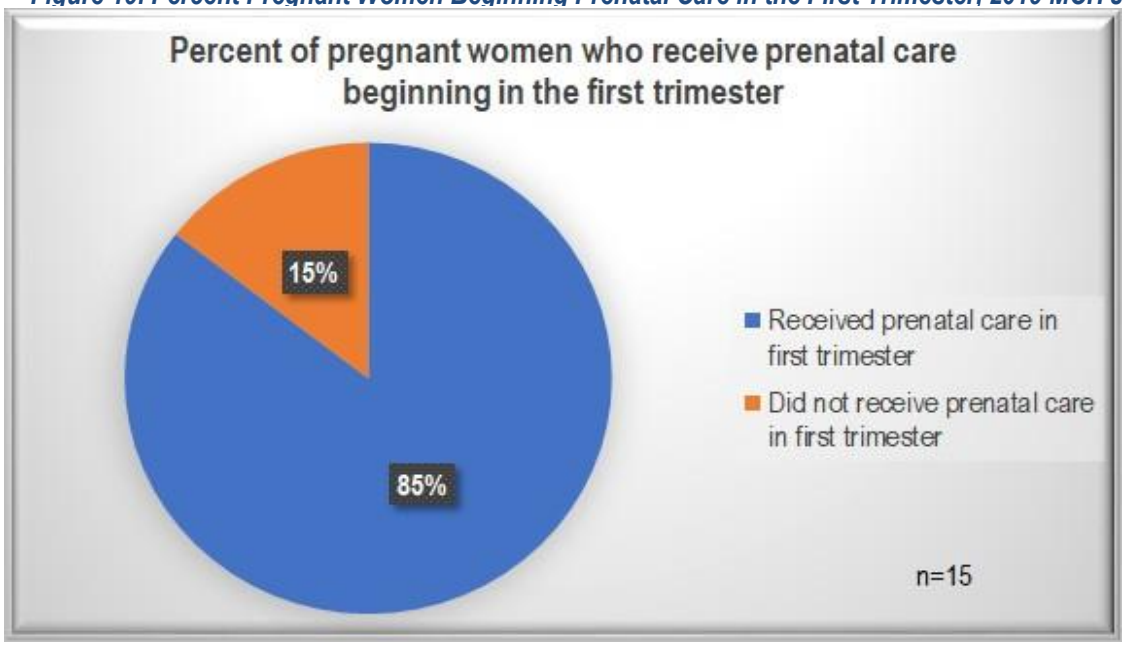
According to the JMCH 2019 survey 15% of children in the sample were born with low birth weight (< 2500 GRAMS). This percentage comports with the findings about children born 3 or more weeks before their due date (15%) (Figure 18).

Figure 18. Percent Low Birth Weight (LBW) Deliveries, 2019 MCH JS



Notably, results from the JMCH/NORC 2019 survey also indicated that nearly nine in every ten pregnant women receive prenatal care beginning in the first trimester (Figure 19).

Figure 19. Percent Pregnant Women Beginning Prenatal Care in the First Trimester, 2019 MCH JS



Additional information to support the 'at-risk' designation of the two districts is included on special education Child Count for children three to five years of age [Appendix I]; Low Birth Weight, Very Low Birth Weight, and Premature birth information [Appendix II] and information on first trimester prenatal visits from UDS data for FQHCs in the Territory [Appendix III]; and detailed information on junior high and senior high school dropout rates, to augment information provided in Section I [Appendix IV].

SECTION III: IDENTIFYING QUALITY AND CAPACITY OF EXISTING PROGRAMS

In this section of the Needs Assessment, attention is given to the data that speak to the quality and capacity of the home visiting services provided by the Healthy Families America and the Nurse Family Partnership programs currently in place in the Territory. The section begins with a description of each program, the approach to the delivery of services, and a description of the current clients served. Following the description of each program, services provided, and clients served, there is a discussion of gaps in the delivery of early childhood home visiting services. Additionally, there is a description of gaps in staffing, community resources, and other requirements associated with delivering evidence-based, home visiting services. Given the current realities of the COVID-19 pandemic, there will also be a description of adjustments that have been made by each program to provide critically needed home visiting services to clients, while adhering to guidance by health professionals relative to public health "best practices" around social distancing to minimize risk for contracting or spreading the virus.

DESCRIPTION OF CURRENT PROGRAMS

Number and Types of Programs and Individuals and Families Receiving Services

Number and Types of Programs

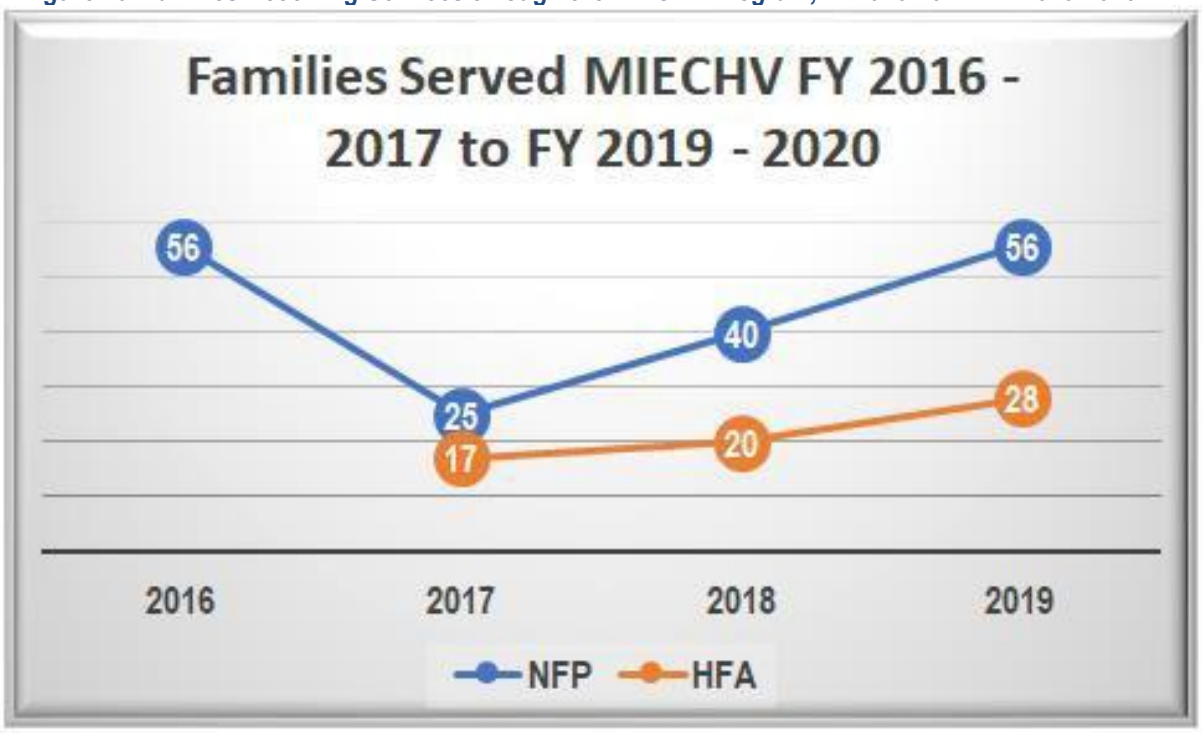
The USVI MIECHV program has implemented two evidenced-based home visiting models; Nurse Family Partnership (NFP) and Healthy Families America (HFA). Each model has the staffing capacity to serve 50 families per district. The MIECHV program collects data to understand the community and the target population it serves and to develop effective, evidence-based strategies to address priority health needs. In FY2019 – 2020 a total of 84 families were served. The program is operating at an estimated 70% of capacity and it is anticipated that the number of families will be increased to reach full capacity in FY2021.

Families are enrolled according to the model guidelines and their interest in the program that is implemented in their district. For the HFA model in the St. Croix District, enrollment options available to families are voluntarily prenatal enrollment or voluntary postnatal enrollment up to thirty days after a birth. In the St. Thomas-St. John District, the

NFP model requires clients to be first time mothers at gestational ages below 28 weeks to be eligible for enrollment.

Families are expected to remain in the NFP and HFA programs for twenty-four months and thirty-six months, respectively. Since 2017 there has been a steady increase in the number of families receiving service through the MIECHV programs in the Territory. Figure 19 below shows the year on year increase in HFA and NFP enrollment from FY 2017-2018 to FY 2019 – 2020.

Figure 20. Families Receiving Services through the MIECHV Program, FY2016-2017 - FY2019-2020



Individuals and Families Receiving Services

Healthy Families America Program

The Healthy Family America (HFA) model focuses on helping families address challenges like single parenthood, low-income, mental health issues, substance abuse, and child abuse or spousal abuse. Trained family support specialists make weekly home visits and assist parents in obtaining screenings and development assessments for their children. The typical client enrolled in the HFA model is single, between twenty and twenty- nine years old, and holds a high school diploma. For most of the HFA clients (75%) Medicaid provides insurance coverage and modal income level is USD 8000 per annum. The racial and ethnic

composition of the beneficiaries in the HFA reflects the demographic makeup of the district and as such Non-Hispanic blacks make up many of the clients while Hispanics comprise one-quarter of total parents served.

Nurse Family Partnership Program

In the NFP model, which accepts only first-time mothers, 27% of the beneficiaries are teenagers (15 – 19 years of age) and use Medicaid for health care insurance coverage. The program assists first-time pregnant mothers and their families in improving prenatal and child rearing practices through the child's second birthday. Specially trained nurses guide pregnant women in cultivating good health practices and prenatal care. The typical client has a high school diploma and is employed on a part-time or full-time basis. The modal income level reported for NFP participants is less than or equal to USD 6000 and 87% of beneficiaries live in households with family and/or others.

To adequately address the needs of the clients, the MIECHV program purchased items for families enrolled in the programs. The items purchased are directly related to the achievement of program goals, such as increasing breast feeding and school readiness. To that end, literature to promote increase knowledge about breastfeeding, breast pumps to support breastfeeding from birth to six months, books for the mothers to read to baby from the womb to birth; books to support school readiness and toys to support the development of fine and gross motor skills and hand-eye coordination were distributed to beneficiaries. Additionally, the program utilizes the PHQ-9 depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day) to assess depressive and other mental disorders commonly encountered in patients postnatally.

GAPS IN EARLY CHILDHOOD HOME VISITING

The Maternal, Infant, Early Childhood Home Visiting program in the USVI is administered by the Department of Health, a government agency and the unit has one vacancy for the position of Assistant Director for Title V. Unlike other jurisdictions, where the program may operate as a non-profit organization, in the USVI the program is not allowed to seek corporate sponsorship to expand its resource base. Therefore, the program primarily provides support to families from its operating budget. The program also provides car seats and carriers for child safety, pampers, bobby pillows, and other safety and health resource

tools to support mothers who may have a financial challenge at any time during enrollment in the program.

Essentially, the MIECHV Program can and does provide support to families based on emergency needs for the infant/toddler, education, and development support. Yet, though there may be legitimate needs in particular areas, the program does not have the flexibility or authority to provide monetary assistance, housing assistance, or emergency shelter to program participants who may have needs in one or more of these areas. There may be some misunderstanding with respect to the scope of support that the MIECHV Program can offer participants; thus, program personnel need to be able to communicate the parameters of the supports available through the program and provide referrals to other organizations and entities across the Territory who may be more appropriate sources of support. However, program personnel note that some organizations from whom support is sought for MIECHV clients who have needs beyond the program's scope, are themselves overburden and are not in a position to support MIECHV clients who may be referred for support services. One such example is around housing, since the Virgin Islands Housing Authority have priority categories for persons who apply for housing and the MIECHV clients may not fall into one of the priority categories. This may result in MIECHV clients having to wait for housing placement or being denied some other services (due to limited resources across agencies). Additionally, MIECHV has no cash or voucher systems to support non-educational or developmental needs of the families, as contrasted with the TANF program administered by the V.I. Department of Human Services.

Over the years, to support clients' needs that are beyond the scope of the MIECHV Program, the program has partnered with the VI Housing Authority, Catholic Charities, Lutheran Social Services, Community Foundation of the Virgin Islands, the Family Resource Center in the St. Croix District, and the Women's Coalition in the St. Thomas-St. John District, along with government agencies, to include the Departments of Education, Human Services, and Labor, as well as faith-based organizations, to support the additional needs of the families in the program.

GAPS IN STAFFING, COMMUNITY RESOURCE(S), AND OTHER REQUIREMENTS

As captured in the organizational charts for the Territory's MIECHV Program (Figures 1 and 2), there continues to be challenges in staffing the program. While six of 10 program position had been filled and were stable, there were four positions that were filled late spring into early summer 2020. However, notwithstanding the filling of the four vacancies, the program experienced the loss of two key staff members, one at the end of the fiscal year (September 2020) and one early in the current fiscal year (November 2020). Thus, gaps in staffing continue to pose an on-going challenge for the program. Because the program functions within budgetary parameters, both in terms of grant funds as well as the VIDOH salary scales, the MIECHV Program losses professional staff, particularly nurses, who can earn higher salaries if they transfer to one of the local hospitals.

The MIECHV Leadership team, with support from the Title V Program Director, will need to develop strategies to mitigate the departure of the nursing staff in the Nurse Family Partnership model. The Leadership team is considering caseload management for new nurses, on-boarding plan for education of the internal and external systems connected to the model. In addition, consideration will be given to instituting cultural sensitivity education, support of reflective supervision for the program supervisors and the team staff, and training on MIECHV data collection tools and systems for new staff. It is anticipated that recruitment efforts will be targeted to increase the likelihood that new hires are retained for a sufficient period of time that both programs become stable in the area of staffing – all positions filled and staff turnover minimal.

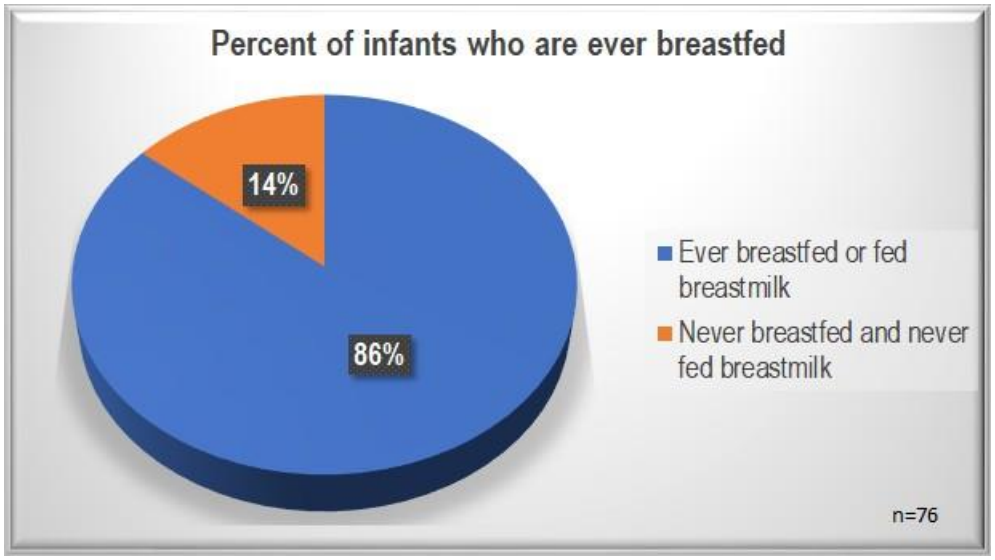
OTHER CONSIDERATIONS

The program has gained positive recognition and increased visibility in the Territory as is evidenced by the increased number of families being served. Ten families graduated from the NFP program and with a full slate of staffing personnel, with two new hires in the capacity of Home Visiting Nurses, the program is poised to achieve the goal of serving 100 families. The hiring of support staff for the program has led to timely performance measure reporting as well as support for the home visiting staff and the administrative leadership of the program. The MIECHV program can provide community-level data that are essential to understanding the connections between health care, and the lived experience of vulnerable and at-risk community residents.

Breastfeeding

The Continuous Quality Improvement (CQI) activities delineated for FY 2017 to January 2019 included a focus on staff retention and the Maternal, Infant, Early Home Visiting (MIECHV) Performance Measure, two – Breastfeeding to six months. The findings from the 2019 MCH JS show that almost nine of every ten infants have been fed breastmilk (Figure 21).

Figure 21. Percent of Infants Ever Breastfed or Fed Breastmilk, 2019 MCH JS



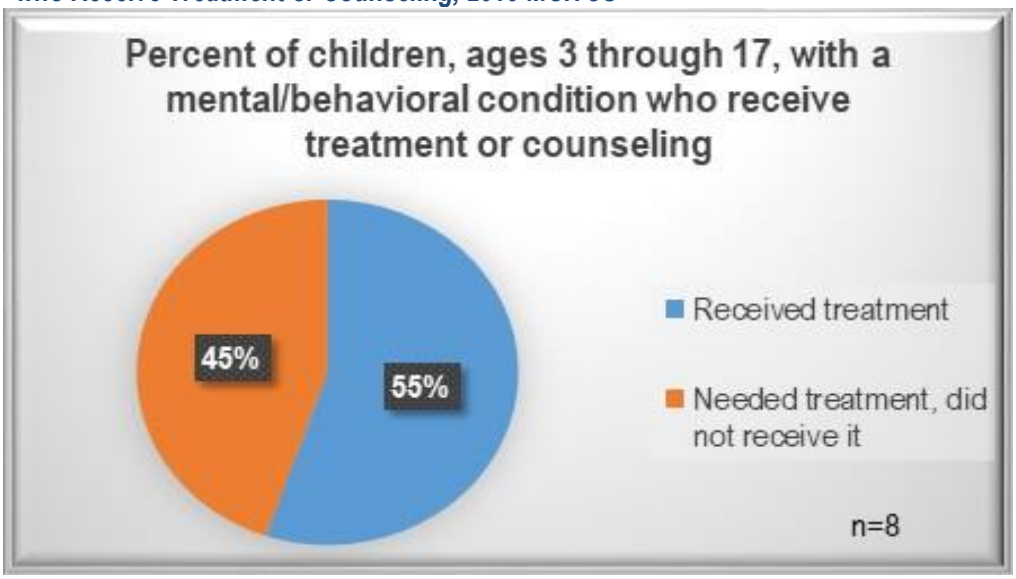
However, based on FY 2016-2017 performance data, from a home visitor pilot study with clients who initiated breastfeeding, as a baseline, all participating mothers breastfed their children at birth and continued breastfeeding into the second month. However, between months three and four, breast feedings were supplemented by bottle feeding or only bottle-fed babies. Based on the pilot study data, it was hypothesized that if mothers were educated on ways to pump and store breastmilk it would increase the likelihood that mothers would continue to breastfeed to six months. The MIECHV program's FY 2017 to 2019 CQI sought to:

i. Provide education on breastfeeding support to 25 % of enrolled mothers to encourage breastfeeding from birth to six months by July 2019 in the NFP model and

ii. Provide full support education for behavioral health referral services by December 2019 to improve service usage Performance Measures data from 16.7 % to 25%.

The 2019 MCH JS/NORC findings from a small sample, show that 45% of children, ages 3 through 17, with a mental or behavioral condition needed treatment but were not able to receive treatment in 2019 (Figure 22).

Figure 22. Percent of Children, Ages 3 through 17, with a Mental/Behavioral Condition who Receive Treatment or Counseling, 2019 MCH JS



Part C and Part B Support for Children, Birth through Five with Special Needs

The recently completed (2020) 2019-2020 Needs Assessment of the USVI's ECE Mixed Delivery System provides extensive information on programs and services available to support children, birth through five years of age with special needs, and to support their families. For FY2017-2018, the Part C, Infant and Toddlers Program reported serving 102 children, 0-3, with approximately 70% being served in their homes. Approximately 60% of the children served were between two and three years of age.

The State Office of Special Education (SOSE) for the Territory reported child count numbers for children ages three to five with special needs/disabilities for SY2014-2015 through SY2017-2018. Total numbers ranged from 98 to 126, with higher counts in the St. Thomas-St. John District for three of the four school years. For children transitioning from Part C to Part B services, the SOSE has set a target of 100% for completion of Individualized Education Plans (IEPs) by the child's third birthday. Data reported for SY2015-2016 through SY2017-2018 indicate the target was met for two of the three years. For SY2017-2018, the school year in which the Territory experienced two Category 5 Hurricanes, 89% of IEPs were completed, by their third birthday, for children transitioning from Part C to Part B in the St. Croix District, while

only 50% of IEPs were completed by the target timeframe for Part C children transitioning to Part B in the St. Thomas-St. John District.

As delineated in their IEPs, children ages three through five receive speech therapy, occupational therapy, physical therapy, vision services, and specialized instructional services at their childcare site. For children who are not enrolled in a childcare center, SOSE staff provide services at a public-school location closest to the child's home or at a VI Department of Education (VIDE) office location closest to the child's home.

Two other areas in which data were provided in the PDG B-5 Needs Assessment that are germane for the MIECHV Program relate to the receipt of special-education related services in ECE settings and parents' views on how their involvement in improving outcomes for their children was facilitated by staff. With respect to the provision of to children three to five years of age based on their IEPs, SOSE set a target to serve 94% of those children. From data shared, the target was met in the St. Thomas-St. John District for two of the three school years, while the target was not met for any year in the St. Croix District. The school year with the lowest percentage of students served in either district was SY2017-2018, with 79% of children with IEPs served in the St. Croix District and 83% of children with IEPs served.

Finally, the SOSE set a target of 83% agreement by parents regarding the extent to which parents of children with special needs reported support/facilitation of parent involvement to improve services and outcomes for children. For the three school years under consideration, SY2015-2016 through SY2017-2018, the SOSE met and exceeded the 83% target, with 85% of parents in the St. Croix District and 86% of parents in the St. Thomas-St. John District affirmed the facilitation of parent involvement to improve services and outcomes for their special needs children.

SECTION IV: CAPACITY FOR PROVIDING SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

The use and abuse of substances can begin with one innocently experimenting in a social setting to 'see what it is like'. Other persons may begin using drugs to cope with physical and or emotional pain. One becomes addicted to a substance when unable to stop consuming the substance even if it causes psychological or physical harm. Addictive substances may be legally prescribed drugs, other non-medicinal substances such as alcohol and cigarettes, as well as illegal drugs. A person who becomes addicted cannot control how they use a substance and becomes dependent on the substance to cope with daily life. Some drugs, such as opioid painkillers, have a higher risk and cause addiction more quickly than others. Once one becomes addicted, cravings for the substance can increase leading to behaviors aimed at obtaining the substance at any cost and the neglect of one's day to day responsibilities. Having available treatment resources for parents of children who are addicted to substances is important to the safety wellbeing and stability of the family.

RANGE OF TREATMENT AND COUNSELING SERVICES

The Division of Behavioral Health, Alcoholism and Drug Dependency Services (BHADDS) within the Virgin Islands Department of Health, with outpatient program sites on St. Croix and St. Thomas. Verbal communication with the program director confirmed that substance treatment services are provided to women who are pregnant and have young children. One BHADDS intervention available for pregnant women and families of young children is Wellness Self-Management Group Therapy designed for those who need assistance with personal recovery from alcohol or illegal and prescribed drugs. The Director also confirmed that appropriate referrals for treatment are made to The Village on St. Croix, the only residential substance use treatment facility in the Virgin Islands. The Village, a part of the WestCare Foundation, (https://westcare.com), provides a comprehensive array of outpatient and residential behavioral healthcare services for persons who present for drug detoxification and treatment.

The Village programs that are available to referred parents of children include individual and group counseling; alcohol and drug education classes; substance abuse and

mental health education classes; medication management, life skills training, substance abuse and mental health relapse prevention; cognitive restructuring and trauma services; and 12-Step meetings. Both Federally Qualified Health Centers (FQHC) on St. Croix and St. Thomas have behavioral health professionals on staff. Services available to pregnant women and families with young children include individual therapy, medication management and case management. The psychiatrist at the St. Thomas East End Medical Center (STEEMCC) indicated that over the past year he treated five clients who fit this profile.

Finally, with respect to treatment and counseling services provided to MIECHV clients, both home visiting programs provided data on referrals made for such services and clients that receive the services. The Healthy Family America (HFA) Program reported making a total of 10 referrals over FY2016-2017 through FY2019-2020. Of those 10 referrals, four were developmental referrals. For the Nurse Family Partnership Program, data were available for only the most recent fiscal year, FY2019-2020. Data provided indicate that a total of 30 referrals were made for 10 clients for services in one of three areas, namely, intimate partner violence (IPV), mental health therapy (MHT), and/or relationship counseling (RC). Referrals were one of five service providers: Beautiful Dreamers, Family Resource Center, St. Thomas East End Medical Center Corp. (FQHC), V.I. Department of Education (school counselor), or Project LAUNCH (VIDOH).

GAPS IN CURRENT LEVEL OF TREATMENT AND COUNSELING SERVICES

While the MIECHV Program did not identify any current program participants in need of treatment or counseling services, it must be noted that there is a shortage of mental health professionals in the Territory who provide services to the uninsured and persons with MAP coverage, thereby limiting the choice of providers for these families across both Districts. Treatment for referred families is available across the Territory through the MHDSAP and the FQHCs. However, as The Village is only located in the district of St. Croix, families in the St. Thomas/St. John District that could be eligible for MIECHV services, and who might benefit from day or residential treatment modalities, do not have these available to them.

BARRIERS TO RECEIPT OF SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

There was no program documentation relative to barriers to receiving treatment for substance use disorders for any program participants.

OPPORTUNITIES FOR COLLABORATION WITH TERRITORIAL AND LOCAL PARTNERS

Project LAUNCH can partner with MIECHV to be a part of its family support services network. The introduction of tools for addressing behavioral health issues that arise in the context of the home visit can enhance the success of home visiting programs by addressing the social and emotional well-being of the young child and the family. (pg. 38 Project LAUNCH CNA)

CURRENT ACTIVITIES TO STRENGTHEN THE SYSTEM OF CARE FOR ADDRESSING SUBSTANCE USE DISORDER

According to the NIH's National Institute on Alcohol Abuse and Alcoholism's (NIAAA's) alcohol and tobacco use may lead to major health risks when used alone and together. These behaviors can result in traumatic death and injury. Alcohol is associated with chronic liver disease, cancers, and cardiovascular disease. Smoking is associated with lung disease, cancers, and cardiovascular disease. Significantly, the NIAAA's reports that evidence suggests that the substances involved with these behaviors might be especially dangerous when they are used together, as alcohol and tobacco combined dramatically increase the risk of certain cancers.

The BRFSS 2016 findings report that 48% of Virgin Islanders have at least one alcoholic drink per day in a month and four in ten consume two – three alcoholic beverage per day during the same period (n=1266).

Studies have shown that implementation of routine voluntary substance abuse screening in prenatal settings is feasible and can be used to identify women at risk because of substance use during pregnancy. It is established that cigarette smoking indicates an increased risk for alcohol use and use of either cigarettes or alcohol indicate an increased risk for marijuana and cocaine use. Pregnant women have been known to continue substance use after learning of the pregnancy.

OTHER CONSIDERATIONS

The Governor of the Virgin Islands, Albert Bryan Jr. recently submitted legislation to the 33rd Legislature with a view to revamp and reform the Territory's mental health system to address gaps in services to residents who suffer from behavioral health challenges, mental health disorders, developmental disabilities, **alcoholism, and drug addiction**.

If enacted, the legislation, to be known as *The Virgin Islands Behavioral Health and Developmental Disability Act,* would establish the Territory's first behavioral health, mental health, developmental disability and **alcohol and substance abuse** facility. The Act will seek to establish inter-departmental coordination between the court, government agencies, private and public facilities, health professionals and nonprofit organizations to address the needs of residents by creating and expanding new divisions, programs, treatments, and patient rights policies. The cross-agency coordination aims to facilitate:

- Residential psychiatric facilities
- Community-based crisis services
- Inpatient and outpatient behavioral health services with case management
- Medication-assisted treatment and associated recovery support
- Detoxification services, and
- Affordable supportive housing

The comprehensive bill is an effort to restructure all behavioral, substance abuse and developmental disabilities provisions into a cohesive structure in one location, since existing mental health provisions are "scattered throughout the V.I. Code and dates back to 1965" according to Governor Bryan. The old Anna's Hope Detention Center on St. Croix has been identified as a proposed site to house this facility.

The legislation calls for the director of the facility to be appointed by the Governor, and the position would be partially supported by funds from the Casino Revenue Fund which has funding designated for hospitals and health. Another key component of the Act is modernizing and reforming the current system using telemedicine and telepsychology. It will enable the use of psychological services via electronic transmission, such as telephone email and internet, to facilitate diagnosis and treatment when local professionals are not available. The legislation also sets out the requirements for licensing and regulation of practitioners of telemedicine and telepsychology services.

A Division of Behavioral Health, Mental Health, Developmental Disability, Alcoholism and Drug Dependency Service would be created within the Health Department and overseen by a director. The director will be required to be a licensed medical practitioner in the field of behavioral health or mental health or a qualified professional who has had a minimum of five years training and experience in relevant social-medical problems and treatment services.

Other aspects of the governance structure, entrenched in the proposed legislation, include a mandate for the formation of the Behavioral Health Council of the Virgin Islands, a citizens' advisory board that would be comprised of seven members who would develop an enforceable set of standards for public and private treatment facilities. Further, the administration and development of the reformed mental health system would fall primarily under the management of the V.I. Health Commissioner, and the Health Department will closely coordinate program development with the Education Department, Bureau of Corrections, V.I. Police Department, Judiciary, Human Services Department and other relevant departments or agencies.

The Act would also establish community service networks that will coordinate and ensure continuity of care; establish a crisis intervention program and crisis intervention team; to provide for protective custody for persons who may be a danger to themselves or others; provide behavioral health training for first-responders and education personnel; and actively participate in competency hearings and other judicial proceedings and criminal issues relating to persons with behavioral and mental health problems. Additionally, the Act outlines rules, procedures and policies governing all aspects of the treatment of behavioral health problems, developmental disability issues, alcoholism and drug dependency, including but not limited to voluntary and involuntary commitment; progressive treatment programs; patient care and patients' rights, for children and young adults; hospitalization outside the Territory and transfers to other facilities; and the use of medication.

SECTION V: COORDINATION WITH TITLE V, HEAD START, AND CAPTA

CONSIDERATION OF REQUIREMENTS IN THE TITLE V MCH BLOCK GRANT PROGRAM NEEDS ASSESSMENT

The team was able to utilize data that were included in the Title V Summary Needs Assessment in the current MIECHV Needs Assessment. In particular, some of the JMCH/NORC data are highlighted. Additionally, information related to low birth weight and very low birth weight deliveries, as well as preterm deliveries are included in Appendix I to augment data included to assess the two districts in the Territory – St. Croix and St. Thomas-St. John – as 'at risk'.

COMMUNITY-WIDE STRATEGIC PLANNING AND NEEDS ASSESSMENTS CONDUCTED IN ACCORDANCE WITH SECTION 640(G)(1)(C)

The USVI's Head Start Program has not completed a community-wide strategic planning and needs assessment activity over the past five years. However, the program relied on the Community Needs Assessment conducted by the Caribbean Exploratory Research Center in the aftermath of Hurricanes Irma and Maria to contextualize needs for the Territory's Head Start Program. The results of that needs assessment were considered in completing this needs assessment, particularly with respect to the section of the needs assessment that focused on select human services programs – specifically Head Start and Early Head Start, as well as the section of the needs assessment that dealt with health, with a review of the information reported on critical health issues for the Territory in the aftermath of two Category 5 hurricanes.

TITLE II OF THE CAPTA INVENTORY OF CURRENT UNMET NEEDS AND CURRENT COMMUNITY-BASED AND PREVENTION-FOCUSED PROGRAMS AND ACTIVITIES TO PREVENT CHILD ABUSE AND NEGLECT

Contact was made with the leadership of the V. I. Department of Human Services, who is the government agency in the Territory that received funds under CAPTA. No data were available relative to an inventory of current unmet needs around child abuse and neglect. However, information was shared that the CAPTA funds that are awarded to the Territory are not managed as a separate funding source, but pooled in the agency's Block Grant funds, and in so doing, separating reporting for CAPTA funds are not done by the

agency and may not be required by the funding agency. Currently, the V.I. Department of Human Services (VIDHS) is the entity responsible for ensuring the safety of children who have been identified as needing to be removed from home situations that increase their exposure to child abuse or neglect. Table 3 (page 17) and Figure 17 (page 18) speak to children in foster care (wards of the VIDHS) and those who have been abused – whether neglected, physically, or sexually abused. While the numbers in both Table 3 and Figure 17 show a declining trend, the national Kids Count Data Center note that the numbers reported for abuse (any type) may underrepresent what is actually happening with respect to child abuse in the Territory.

EFFORTS TO CONVENE STAKEHOLDERS TO REVIEW AND CONTEXTUALIZE RESULTS OF MIECHV NEEDS ASSESSMENT

A survey was developed for the Advisory Committee to complete upon review of the MIECHV Needs Assessment. The advisory committee has a copy of the Title V Needs Assessment Summary and participated in a virtual session to review Title V Block Grant and to receive updates on the MIECHV Program Needs Assessment as well as the Title V Program Needs Assessment.

PROCESS ESTABLISHED TO ENSURE ONGOING SHARING OF NEEDS ASSESSMENT FINDINGS WITH REPRESENTATIVES OF TITLE V MCH BLOCK GRANT, HEAD START, AND CAPTA

The MIECHV Program intends to post the final version of the needs assessment on the VIDOH website and share electronic copies with representatives of key partner agencies. Representatives will also be invited to participate, if their schedules allow, in the Title V Block Grant review activity on October 6, 2020.

SECTION VI: CONCLUSION

This needs assessment has sought to determine the extent to which the MIECHV program has met its mandate to strengthen and improve programs and health outcomes for at risk families in the Virgin Islands. The program aimed to strengthen and improve service coordination, and services provided to women, infants, children, and adolescents (including children and adolescents with special healthcare needs). Indicators for participation in the MIECHV programs reflect five domains, namely, socio-economic status (SES), adverse perinatal outcomes, substance use disorder, crime, and child maltreatment. Program services were reviewed to determine the level of success in providing needed services to this population, and to identify any gaps and areas in need of improvement. This process involved accessing existing administrative data generated by various entities, the Virgin Islands Community Survey, various needs assessments, and other secondary sources and published reports. Additionally, the Project Team reviewed program reports and documents, communicated with key members of the MIECHV Program and reviewed documentation from sources that contextualized the socioeconomic reality of living in the Territory.

SUMMARY OF MAJOR FINDINGS

Based on extensive review and assessment of the MIECHV program documents, primary and secondary data and related sources, the following key findings are evident.

With respect to the socio-economic context of the Territory:

- The 2019 mean annual wage for all occupations in the Virgin Islands was $45,970 compared to the U.S. mean wage of $53,490.
- The unemployment rate increased from a low of 4.5% in January 2020, to a high of 13.5% in April 2020.

With respect to the status of children and youth in the Territory:

- In 2019, 30% of Virgin Islands children were living in poverty as compared to the 13.5% of U.S. children living in poverty.
- In 2015, 18.9% of all VI children and youth, ages birth through 19 (4,022 children) lacked health insurance and 12.8% of VI children under age 5 were uninsured.
- For SY 2017-2018, 9% (59 students) graduated with a disability, and 4.4% (29 students) graduated with limited English proficiency.
- Virgin Islands children transitioning from preschool to kindergarten in 2018 underperformed in the areas of cognitive, language and self-help with over 31% lacking these skills.

- Neglect is the primary type of child abuse of Virgin Islands children with 34 children being placed in protective and foster care in 2019.

With respect to health outcomes and health practices for MIECHV clients:

- Territory wide, the rate of premature births per 1,000 live births ranged from a low of 73.7 in 2016 to a high of 111.7 in 2018.
- Nearly nine in ten pregnant women receive prenatal care beginning in the first trimester.

With respect to behavioral health:

- Behavior health treatment for referred families is available through the MHDSAP and the FQHCs across the Territory, and The Village on St. Croix.
- There is a shortage of mental health professionals in the Territory who provide services to the uninsured and persons with MAP coverage.
- The Governor of the Virgin Islands has submitted a bill to the 33rd Legislature which, if enacted, would revamp and reform the Territory's mental health system and restructure all behavioral, substance abuse and developmental disabilities provisions into a cohesive structure in one location.

With respect to key programs that support at risk pregnant women and children:

- In FY2019 – 2020 a total of 84 families were served by two evidenced-based home visiting models; Nurse Family Partnership (NFP) and Healthy Families America (HFA).
- The USVI WIC Program maintains the highest breastfeeding rate in the Mid-Atlantic Region and continues to be among the top 10 for highest breastfeeding rates in the nation.

With respect to MIECHV Program capacity:

- The MIECHV Program continues to have challenges with staffing, particularly around retaining professional staff, particularly nurses, and filling vacancies, in part due to compressed salary scales.
- Key support staff have been hired and have been supporting key aspects of the program.

With respect to availability of data:

- There were challenges securing data to address Title II of CAPTA.
- There is inconsistency in the type and breadth and depth of data collected by the two home visiting programs being implemented as part of MIECHV.

DISSEMINATION OF MIECHV NEEDS ASSESSMENT UPDATE TO STAKEHOLDERS

The final version of the needs assessment will be shared electronically and an Executive Summary highlighting the key findings will be developed and shared with key stakeholders.

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7. U.S. Virgin Islands Department of Health. Maternal, Infant and Early Childhood Home Visiting Program. Supplemental Information Request Needs Assessment. (2011). USVI.
8. Virgin Islands Department of Education. Office of Planning, Research and Evaluation. https://www.vide.vi/our-divisions/planning-research-and-evaluation.html#reports.
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SUPPORTING DOCUMENTATION

APPENDIX I: SUPPLEMENTAL CHILD COUNT DATA – SPECIAL EDUCATION SERVICES

December 1, 2015, Child Count Data by Disability Category

District	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	
	Autism	Developmentally Delay	Emotional Disturbance	Hearing Impairments	Intellectual Disabilities	Multiple Disabilities	Other Health Impairments	Orthopedic Impairments	Specific Learning Disabilities	Speech or Language Impairments	Traumatic Brian Injury	Visual Impairments	Grand Total
St. Croix	66	47	19	2	55	15	71	2	333	23	2	1	636
St. Thomas-St. John	34	81	11	2	51	6	30		260	92		4	571
Grand Total	**100**	**128**	**30**	**4**	**106**	**21**	**101**	**2**	**593**	**115**	**2**	**5**	**1207**

December 1, 2016, Child Count Data by Disability Category

District	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	
	Autism	Developmentally Delay	Emotional Disturbance	Hearing Impairments	Intellectual Disabilities	Multiple Disabilities	Other Health Impairments	Orthopedic Impairments	Specific Learning Disabilities	Speech or Language Impairments	Traumatic Brian Injury	Visual Impairments	Grand Total
St. Croix	57	39	21	1	54	13	79	2	344	19	3	1	633
St. Thomas-St. John	42	64	8	2	48	6	43		253	92		3	561
Grand Total	**99**	**103**	**29**	**3**	**102**	**19**	**122**	**2**	**597**	**111**	**3**	**4**	**1194**

December 1, 2017, Child Count Data by Disability Category

District	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	
	Autism	Developmentally Delay	Emotional Disturbance	Hearing Impairments	Intellectual Disabilities	Multiple Disabilities	Other Health Impairments	Specific Learning Disabilities	Speech or Language Impairments	Traumatic Brian Injury	Visual Impairments	Grand Total
St. Croix	53	45	14	1	52	13	82	319	27	4	1	611
St. Thomas-St. John	41	60	8	1	42	4	37	217	81		3	494
Grand Total	**94**	**105**	**22**	**2**	**94**	**17**	**119**	**536**	**108**	**4**	**4**	**1105**

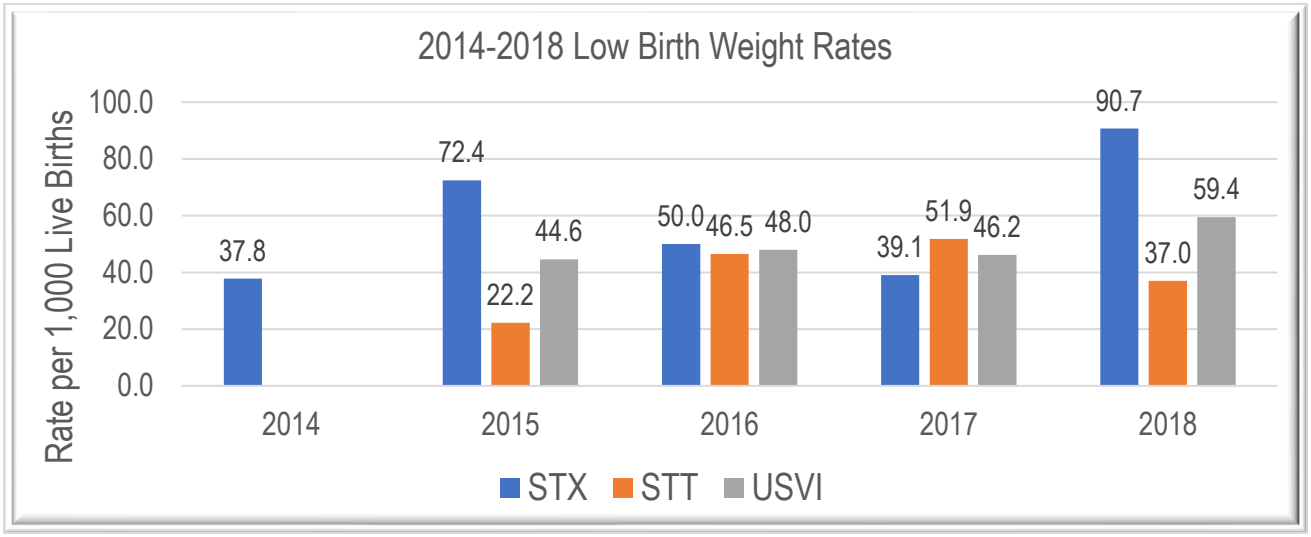
December 1, 2018, Child Count Data by Disability Category

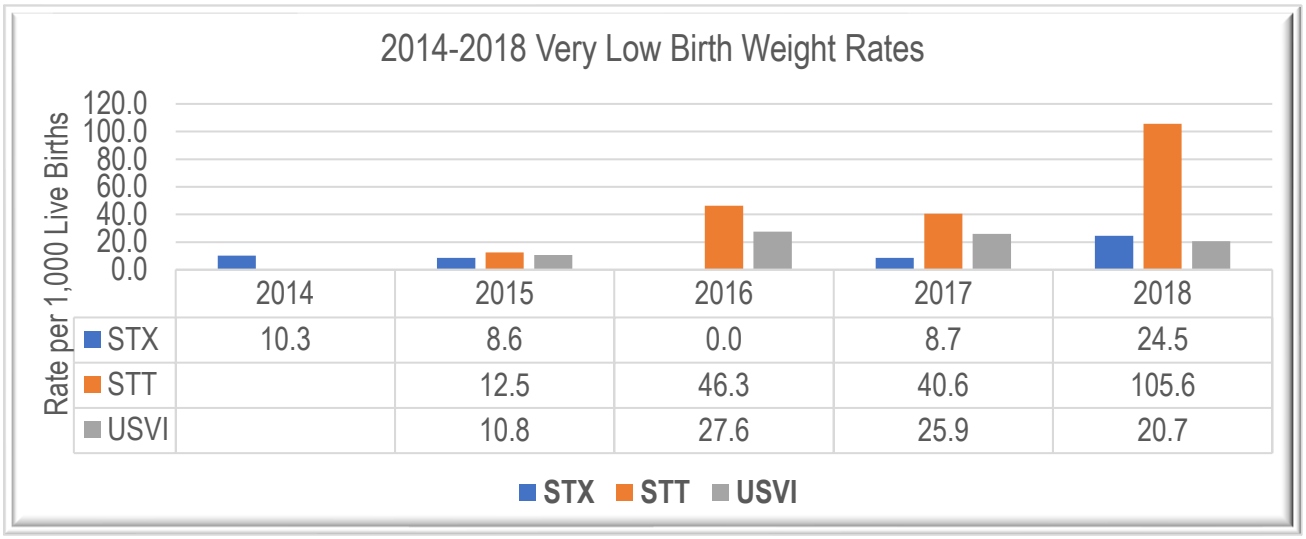
District	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	
	Autism	Developmentally Delay	Emotional Disturbance	Hearing Impairments	Intellectual Disabilities	Multiple Disabilities	Other Health Impairments	Orthopedic Impairments	Specific Learning Disabilities	Speech or Language Impairments	Traumatic Brian Injury	Visual Impairments	Grand Total
St. Croix	59	45	15	1	50	6	67		316	21	4	1	585
St. Thomas-St. John	46	46	11	1	39	5	38	1	220	70		2	479
Grand Total	**105**	**91**	**26**	**2**	**89**	**11**	**105**	**1**	**536**	**91**	**4**	**3**	**1064**

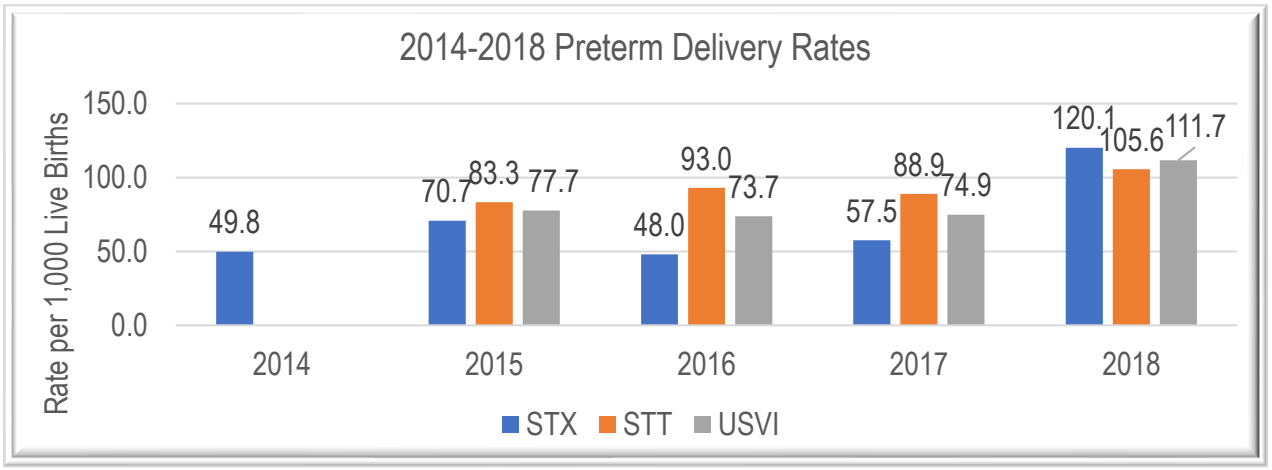
December 1, 2019, Child Count Data by Disability Category

District	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	Disability	
	Autism	Developmentally Delay	Emotional Disturbance	Hearing Impairments	Intellectual Disabilities	Multiple Disabilities	Other Health Impairments	Orthopedic Impairments	Specific Learning Disabilities	Speech or Language Impairments	Traumatic Brian Injury	Visual Impairments	*Grand Total*
St. Croix	*61*	*48*	*22*	*1*	*44*	*6*	*68*		*321*	*25*	*4*	*1*	*601*
St. Thomas-St. John	*47*	*50*	*9*	*2*	*38*	*7*	*48*	*2*	*221*	*75*		*3*	*502*
Grand Total	***108***	***98***	***31***	***3***	***82***	***13***	***116***	***2***	***542***	***100***	***4***	***4***	***1103***

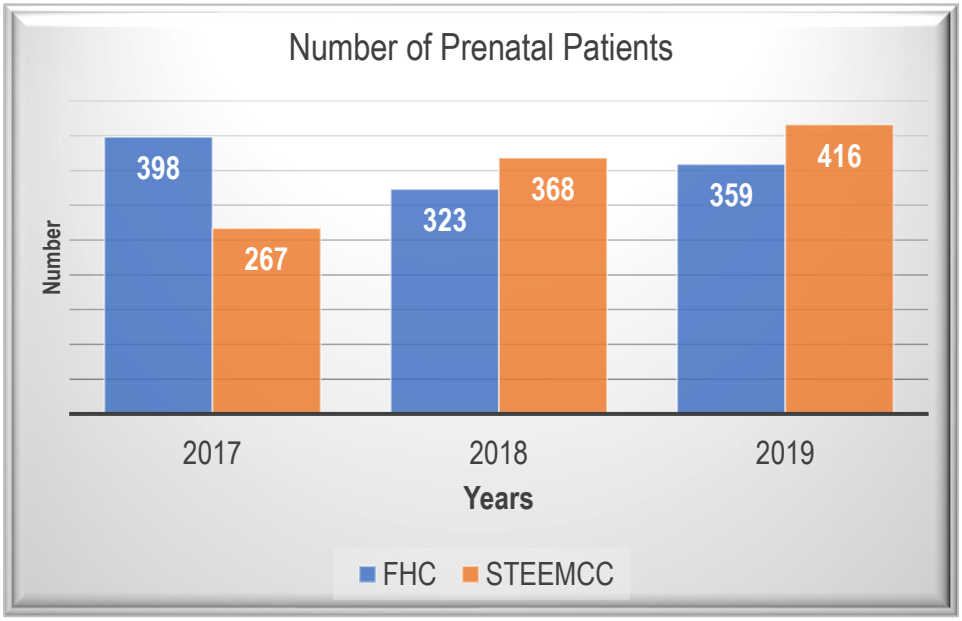
APPENDIX II: SUPPLEMENTAL DATA ON LOW AND VERY LOW BIRTH WEIGHT AND PRETERM BIRTHS



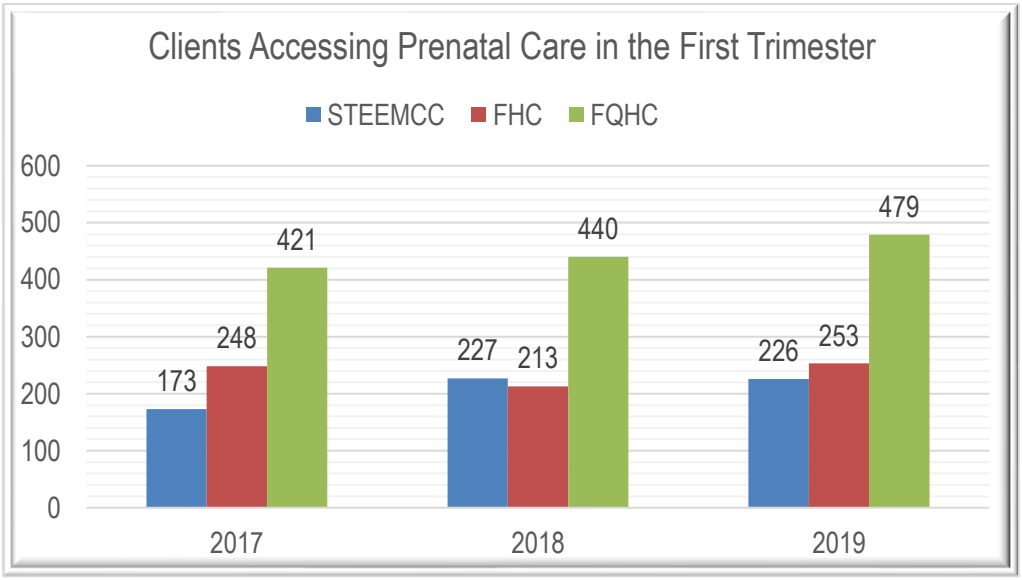




APPENDIX III: SUPPLEMENTAL DATA ON PREGNANT WOMEN RECEIVING CARE IN THE FIRST TRIMESTER



Source: HRSA UDS Data, FQHCs, US Virgin Islands



Source: HRSA UDS Data, FQHCs, US Virgin Islands

APPENDIX IV: DROP OUT DATA FOR JUNIOR AND SENIOR HIGH SCHOOLS

Virgin Islands Department of Education

Office of Planning, Research and Evaluation
Public Schools Dropout by School
2015-2016 to 2018-2019

District/School	2015-2016			2016-2017			2017-2018			2018-2019		
	Dropout	Enrolled	Rate	Dropout	Enrolled	Rate	Dropout	Enrolled	Rate	Dropout	Enrolled	Rate
St. Croix District	**134**	**3048**	**4.4%**	**91**	**2927**	**3.1%**	**99**	**2572**	**3.8%**	**97**	**2508**	**3.9%**
Arthur A. Richards Junior High School	5	412	1.2%	5	351	1.4%	4	262	1.5%	2	272	0.7%
Elena L. Christian Junior High School	2	307	0.7%	3	262	1.1%	0	219	0.0%	8	230	3.5%
John H. Woodson Junior High School	5	313	1.6%	1	329	0.3%	14	321	4.4%	4	287	1.4%
St. Croix Central High School	52	1027	5.1%	47	972	4.8%	58	900	6.4%	47	832	5.6%
St. Croix Educational Complex High School	70	989	7.1%	35	1013	3.5%	23	870	2.6%	36	887	4.1%
St. Thomas/ St. John District	**170**	**3387**	**5.0%**	**156**	**3213**	**4.9%**	**383**	**2595**	**14.8%**	**130**	**2599**	**5.0%**
Addelita Cancryn Junior High School	6	531	1.1%	13	526	2.5%	54	433	12.5%	19	488	3.9%
Bertha C. Boschulte Middle School	14	492	2.8%	5	450	1.1%	2	425	0.5%	12	371	3.2%
Julius E. Sprauve School	2	78	2.6%	0	65	0.0%	16	66	24.2%	1	50	2.0%
Charlotte Amalie High School	63	1359	4.6%	91	1239	7.3%	160	1003	16.0%	41	993	4.1%
Ivanna Eudora Kean High School	85	927	9.2%	47	933	5.0%	151	668	22.6%	57	697	8.2%
Virgin Islands	**304**	**6435**	**4.7%**	**247**	**6140**	**4.0%**	**482**	**5167**	**9.3%**	**227**	**5107**	**4.4%**

District/School	2015-2016			2016-2017			2017-2018			2018-2019		
	Dropout	Enrolled	Rate	Dropout	Enrolled	Rate	Dropout	Enrolled	Rate	Dropout	Enrolled	Rate
St. Croix District	**122**	**2016**	**6.1%**	**82**	**1985**	**4.1%**	**81**	**1770**	**4.6%**	**83**	**1719**	**4.8%**
St. Croix Central High School	52	1027	5.1%	47	972	4.8%	58	900	6.4%	47	832	5.6%
St. Croix Educational Complex High School	70	989	7.1%	35	1013	3.5%	23	870	2.6%	36	887	4.1%
St. Thomas/ St. John District	**148**	**2286**	**6.5%**	**138**	**2172**	**6.4%**	**311**	**1671**	**18.6%**	**98**	**1690**	**5.8%**
Charlotte Amalie High School	63	1359	4.6%	91	1239	7.3%	160	1003	16.0%	41	993	4.1%
Ivanna Eudora Kean High School	85	927	9.2%	47	933	5.0%	151	668	22.6%	57	697	8.2%
Virgin Islands	**270**	**4302**	**6.3%**	**220**	**4157**	**5.3%**	**392**	**3441**	**11.4%**	**181**	**3409**	**5.3%**

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October 1, 2019