Healthy Virgin Islands 2030 Community Health Improvement Plan

UNITED STATES VIRGIN ISLANDS | DEPARTMENT OF HEALTH

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The Healthy Virgin Islands 2030 Community Health Improvement Plan was produced by the U.S. Virgin Islands Department of Health in collaboration with community partners and other territorial agencies. This plan was developed with funding by the Centers for Disease Control and Prevention and technical assistance from the Association of State and Territorial Health Officials.

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Preface

April 2022

On behalf of the U.S. Virgin Islands Department of Health, I am pleased to share the **Healthy Virgin Islands 2030 Community Health Improvement Plan**. This is the third and final strategic document that the department of health has developed with its partners as part of the Healthy Virgin Islands 2030 health planning initiative.

This plan is the culmination of a collaboration between the department, our sister agencies, leaders from community organizations, and members of the public. It was designed ***for the community***. Every priority, goal, and measure was selected for our community so that we can thrive together. We know that health is not just about the individual, but is a partnership with providers, families and neighbors. We also know that not everyone is as healthy as they would like to be, sometimes because it is difficult to access the things that help us attain good health. This plan is designed to embark on breaking down the most challenging of those barriers over the tenure of Healthy Virgin Islands 2030 and address those social determinants of health that impact population health.

This improvement effort was created while we were faced with the biggest threat to our health that many of us will see in our lifetimes: COVID-19. As commissioner, I saw firsthand what communities can do to stay healthy when faced with a common threat. There is power in what we have achieved here in the U.S.Virgin Islands. Yet, the pandemic made gaps in our health care even wider, as we postponed doctors visits and saw a rise in illnesses, and progression of, chronic diseases. We will do better together as we heal, while honoring the lives of those we loved and lost to this disease.

The **Healthy Virgin Islands 2030 Community Health Improvement Plan** is a beginning and a living document. With my agency as a leader and convener, health improvement is now in our hands, supported by community leaders and backed by evidence-based strategies. You are invited to help us build a better system that will support better health for all, now and into the future. Join us in creating a healthy U.S. Virgin Islands.

Sincerely,

Justa E. Encarnacion,
U.S. Virgin Islands
Health Commissioner and Chief Public Health Officer

Introduction

What is a Community Health Improvement Plan?

Every public health department aims to improve the health of the community it serves. By fulfilling the three core functions of public health—assessment, assurance, and policy development—a public health department does its work by engaging in a cycle of improvement. With assessment, the public health department identifies inequities in health among residents and determines why those differences are present. With assurance, the public health department and partners collaborate to develop and implement legal and programmatic remedies to improve community health. With policy development, the public health department partners with the community to develop and implement solutions to health challenges at a population level for the long term.

Achieving health for every resident means acknowledging that not every resident has the same opportunities to attain their best health. There are many barriers to achieving individual health, including economic, social, commercial, and biological factors. For example, persons born with physical disabilities require more healthcare and environmental accommodations than those without physical disabilities Historically, entire populations with a shared identity—such as people of color or people who identify as LGBTQ—have not been able to achieve their best health because of structural discrimination.

> Today's modern public health department pursues health improvement as a fundamental approach, understanding that health must be pursued at many levels in society—not just within the doors of a hospital or clinic.

In order to create a more equitable place to become and remain healthy, the public health system must commit its resources to improvement. In this sense, the public health system is not just the department of public health in a community, but a larger network of government agencies and private organizations with responsibilities connected to community health and wellness. A community health improvement process is a systematic, multi-year effort to make people healthier. High-functioning public health departments lead this long-term cycle of improvement beginning with a written community health improvement plan (CHIP), a concrete blueprint for improving health that accounts for a community's current health and established best and promising practices. A CHIP belongs to the community and is developed and put into action collaboratively with leaders from the public health system. A CHIP answers the question, "How will we reduce health inequities in our community?" More than just a plan, the CHIP is a document that enables a community to hold a

public health system accountable for creating an environment to achieve personal health and wellness.

What Is Healthy Virgin Islands 2030?

The Healthy Virgin Islands 2030 Community Health Improvement Plan describes a set of health priorities and strategies that USVI will adopt and implement to **reduce health inequities** and **improve health outcomes** in USVI for its residents. This plan was developed based on the following vision and mission established by the U.S. Virgin Islands Department of Health (USVI DOH) and its community partners as part of the **Healthy Virgin Islands 2030** initiative, a long-term health improvement planning process.

Healthy Virgin Islands 2030 Vision

> Trusted systems supporting healthy people in healthy communities for a healthy Virgin Islands.

Healthy Virgin Islands 2030 Mission

> To promote public health through healthy behaviors, preventing injury and disease, assuring safe environments, and the delivery of quality healthcare for all.

This deliberate process aims to develop an approach to improve the health of USVI residents by the year 2030 in alignment with the national Healthy People 2030 initiative. The overarching framework for the health planning process is the Mobilizing for Action through Planning and Partnerships (MAPP) framework, a community-driven strategic planning process for improving community health developed by the National Association of County and City Health Officials (NACCHO). MAPP is a six-phase process that emphasizes partnership with community representatives and close collaboration with organizations and agencies with responsibility for improving the health and wellness of communities. The MAPP framework was adapted to a territorial context (see **Figure 1.1**). For example, USVI DOH does not have a traditional local public health system with separate local public health departments. Instead, it operates as two health districts: St. Croix and St. Thomas/St. John/Water Island.

The health planning process was designed to culminate with three strategic products with distinct but related goals. Each of these products supports the development of the others and, the products are intended to be aligned around a common vision of health improvement.

COMMUNITY HEALTH ASSESSMENT | A **community health assessment** is a document that presents analyses of trends in health of a population. These assessments examine the health of an entire community and identify disparities across subgroups within that community across a number of health indicators.

STRATEGIC PLAN | A **strategic plan** is a roadmap for a public health department to improve how it delivers the essential services of public health. The plan describes a strategic map identifying several priorities for change that the department must pursue in order to achieve organizational excellence.

COMMUNITY HEALTH IMPROVEMENT PLAN | A **community health improvement plan** is a detailed plan that targets health inequities with programmatic and policy changes. The plan, developed in collaboration with governmental partners, community leaders, and broad community engagement, lays out strategies that are implemented and monitored for effectiveness over a specified period of time.

The Healthy Virgin Islands 2030 Community Health Improvement Plan report completes the cycle of strategic documents and details specific strategies that USVI DOH and its partners will implement collaboratively to achieve healthier, more equitable outcomes for USVI residents by the end of 2030.

Figure 1.1 | **Framework for the U.S. Virgin Islands Health Planning Process**

SOURCE | U.S. Virgin Islands Department of Health (adapted from the National Association of County and City Health Officials)

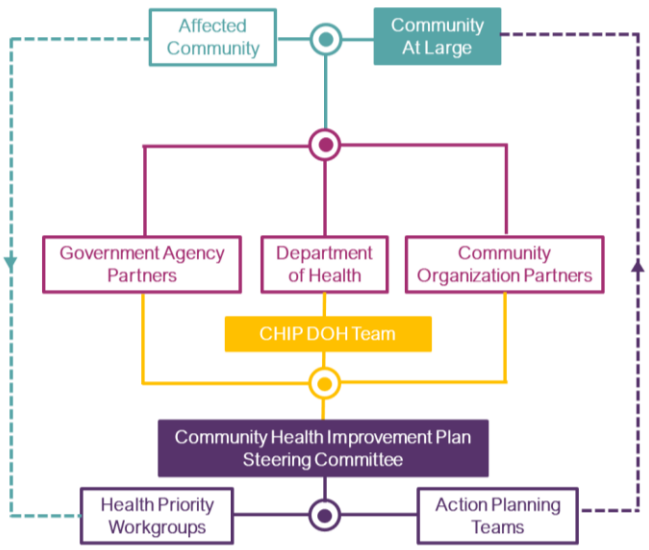
How Was This Plan Developed?

Developing and implementing a community health improvement process is a long-term endeavor that requires careful management, identification of health priorities and strategies, community engagement, financial and political support, and a commitment by all parties to achieve success. The first year of the improvement process is the development of the written CHIP, which requires the formation of a partnership between the department of health, leaders from other government agencies and private organizations, and the community. The remainder of this document describes how USVI DOH implemented this early planning process in preparation of long-term health improvement work.

Overview of the Process

Community health improvement begins with the development of a long-term partnership. The heart of improvement is a collaborative process where many voices are represented and heard over an iterative, long-term cycle. Those voices must include both public health department leaders and members of the community. USVI DOH began the main part of its CHIP planning process during the early throes of the COVID-19 pandemic. The health agency appointed a small internal team to serve as the CHIP team to manage the report planning process. Because of uncertainty related to the epidemiology of SARS-CoV-2, the health agency made a deliberate decision to keep the organizational governance structure of CHIP planning small and included both internal leaders from USVI DOH and leaders from community organizations and government agencies (see Figure 1.2). Originally, USVI DOH intended to include in-person representation from key population groups, but this was not possible due to the pandemic. The entire planning process was conducted virtually.

Figure 1.2 | **U.S. Virgin Islands Community Health Improvement Organizational Structure**



SOURCE | U.S. Virgin Islands Department of Health

USVI DOH used the stakeholder wheel (see Figure 1.3) to identify government agency and community organization stakeholders from different sectors to include in a CHIP steering committee. The health agency began recruiting for the USVI CHIP Steering Committee in early 2020 but paused at the beginning of the pandemic when health agency resources were redirected temporarily as part of the early response to COVID-19. USVI DOH returned to the CHIP process in late summer 2020, recruiting a small but diverse group to form the USVI CHIP Steering Committee. In the future when pandemic restrictions are lifted, the health agency hopes to broaden the committee and extend its improvement coalition. The inaugural meeting of the steering committee took place virtually in November 2020. Appendices A and B presents the charter that members developed to guide their collaborative work and a list of the members of the USVI CHIP Steering Committee.

Figure 1.3 | **Stakeholder Wheel**

SOURCE | U.S. Virgin Islands Department of Health (adapted by ASTHO from the Connecticut Department of Public Health)

Health Priority and Strategy Development

After developing its charter, the CHIP Steering Committee began the process of selecting health priorities by reviewing the findings of the Community Health Assessment report, published in 2020. The committee also voiced the importance of including USVI resident insights more directly, but safely, as strategies such as community forums were not possible. In late February 2021, USVI DOH fielded a community survey that gathered 557 responses and provided the committee with both quantitative and qualitative community opinions to inform health priority selection. Survey respondents were predominantly female and represented every island, with 41% of responses coming from St. Croix, 51% from St. Thomas, and 7% from St. John. One in five (21% of) survey respondents described their health as fair or poor, and 70% of respondents said that seniors were more likely to have worse health than other groups. A summary of survey results is available in Appendix C.

USVI DOH developed a list of 34 potential health priorities based on the community health assessment report and the community survey. The CHIP Steering Committee engaged in a deliberate and systematic process over three virtual meetings to select and recommend three to six health priorities for USVI DOH to adopt. The committee worked in small groups to develop longer-term strategies for each priority area. The committee also applied a cross-cutting approach to developing strategies based on the community health assessment and community survey data to 1) reduce health inequities and 2) improve the health of priority populations (men, children, and seniors). The committee developed strategies for each health priority by creating prevention goals that were tied to metrics aligning with either Healthy People 2030 or the goal of improving on the 2020 community health assessment baseline. Some strategies were deliberately developed to be completed by 2030, while other strategies are longer-term and intended to be carried out through subsequent improvement cycles.

Review and Plan Development

The CHIP team prepared a draft of this report that presented the recommendations of the CHIP Steering Committee. Each member of the steering committee reviewed the draft document before it was presented to the commissioner and executive committee. During the review process, the steering committee sought expertise from external partners in key areas. For example, the committee received and incorporated written feedback from experts in oral health to develop the strategies for that priority. The commissioner and USVI DOH Executive Committee finalized the CHIP health priorities and strategies for publication on the health agency's website.

Health Priorities

U.S. Virgin Islands Community Health Improvement Plan

Health Priorities

This section of the CHIP outlines the five USVI health priorities for improvement over the first five years of Healthy Virgin Islands 2030. This report will be revisited and revised for the final five years of the initiative. Each priority area identifies specific goals to achieve by 2030 with measurable objectives. Each target has been cross-walked with the Healthy People 2030 objectives and, where possible, the U.S. Healthy People 2030 target is presented as a comparison. Each objective lists a set of broad-reaching strategies that USVI DOH and its community partners will use to improve upon the targeted metrics. These strategies are a starting point and are intended to be revisited, as implementation is ongoing.

Cross-Cutting Strategies

The CHIP Steering Committee uncovered two approaches that were common to its visioning of the health priority areas: 1) reducing health inequities and 2) improving the health of priority populations. These approaches, as described below, were applied to the selection of goals, objectives, measures, targets, and strategies presented for each priority area.

1. Reducing Health Inequities

The community health assessment 2020 report and input from the community survey revealed concern about the differences between population groups on measures of health and healthcare access, particularly those attributable to structural and systemic problems, such as racism. The strategies in this CHIP target populations that have experienced inequities in accessing health programs and services, with evidence-based approaches designed for community implementation.

2. Improving the Health of Priority Populations

The assessment phase of health planning revealed that some populations—men, children and adolescents, and seniors—were at high risk for poor health outcomes. **Strategies targeting these high-risk groups are identified by icon in the report, as shown below:**

How the Priorities are Presented

In this report, there are five priorities to improve community health and one priority to improve the infrastructure needed to achieve improvements toward the other five priorities:

Priority 1: Access to Primary and Specialty Care

Priority 2: Chronic Disease Burden

Priority 3: Behavioral and Mental Health

Priority 4: Oral Health

Priority 5: Injury and Violence Prevention

Priority 6: Public Health Infrastructure

Each priority area presents a set of goals, objectives, targets, and strategies. Goals are written to explain the desired result of improvement work in the priority area. For each goal, the CHIP presents objectives aimed at specific diseases, conditions, or populations. Progress toward achieving each objective will be assessed by Healthy People 2030 measures. For each measure, the report presents data from the community health assessment report (if available) benchmarked against national data. **Since Healthy Virgin Islands 2030 is a ten-year initiative, many measures presented may require ten years or more to achieve.** The steering committee selected measures that would allow USVI DOH to assess long-term progress toward goals. The graphic below demonstrates how this report presents goals, objectives, measures, targets, and strategies for each priority area:

Sample Goal: Reduce disease

Sample Objective: Reduce specific disease among a specific population				
		Baseline	2030 Target	Strategies
Measure that will determine whether the objective has been met	U.S.	Current national data on this measure if available (Healthy People 2030 objective number)	Desired improvement level by Healthy People initiative to be achieved by 2030	A list of evidence-based strategies that will be developed into programs, policies, and infrastructure changes in order to meet the 2030 target.
	USVI	Current USVI data on this measure from the 2020 Community Health Assessment report or other data source if available	Desired improvement level by Healthy People initiative to be achieved by 2025 (5-year target) or 2030 and beyond (10-year target).	

Inclusion of Public Health Infrastructure as a Health Priority

The USVI public health system includes the health agency, public health and private laboratories, and our two hospitals, as well as nongovernmental public and private agencies, voluntary organizations, and private individuals. Federal agencies are also important partners who provide public health support via annual funding and technical assistance. Implementing strategies to improve population health is grounded in a strong public health infrastructure, and the key components of such an infrastructure include public and private agencies and organizations working together synergistically to assess and respond to public health needs and up-to-date data and information systems, to include a health information exchange and a qualified and capable workforce.

Public health infrastructure improvement is typically not part of a CHIP, but USVI is not a typical setting for improvement work. The public health infrastructure priority proposed for this CHIP address planning and partnerships, a high-performing health department and healthcare system, continuous workforce development and training, and reliable data and information systems. These steps are foundational to achieving all other goals in the CHIP. This priority area is also present in our strategic plan, and USVI DOH will be working internally to realize the goals of this important priority area.

Data Gaps in this Report

USVI DOH recognizes that some of the measures in the CHIP that will be used to assess progress toward objectives do not have recent data. One of the major goals of the department's strategic plan is to develop data and surveillance systems that fill these gaps and support long-term performance monitoring. As noted, USVI has made improving public health infrastructure a priority, and each workgroup responsible for developing priority implementation plans must include a plan for collecting data, including a baseline.

Priority 1: Access to Primary and Specialty Care

Goal 1.1: Reduce vaccine-preventable disease.

Objective 1.1.1 Increase rates of recommended vaccinations among young children.

		Baseline	2030 Target	Strategies
 Measles-mumps-rubella (MMR) vaccination coverage for children in kindergarten	U.S.	• 94.7% of children enrolled in kindergarten received two or more doses of MMR for the 2018-2019 school year (IID-04). • 90.8% of children born in 2015 received at least one dose of MMR by their second birthday (IID-03).	• 95.0% • 90.8%	• Promote prenatal care that includes counseling related to vaccination. • Build partnerships with community organizations to promote receipt of recommended vaccinations for children. • Reduce financial barriers to seeking vaccination. • Develop targeted strategies based on racial and ethnic, age, disability, social, economic, cultural, and other factors that contribute to disparities in vaccination rates. • Expand vaccination sites to non-traditional sites such as pharmacies, OB-GYN practices, other specialty healthcare settings, and non–healthcare settings such as schools, workplaces, places of worship, and community centers. • Promote vaccination as normal and healthy while addressing concerns and dispelling misinformation via social media. • Adopt community health worker strategies to increase child vaccination.
	USVI	• Two-dose data is unavailable. 70.5% of children ages 19 to 35 months received at least one dose in 2016.	• Target will be defined in Year 1 of implementation.	
 All recommended vaccines by 35 months	U.S.	• 1.3% of children born in 2015 had received 0 doses of recommended vaccinations by their second birthday (NIS-Child).	• 1.3% (maintain)	
	USVI	• 45.7% of USVI children got all recommended vaccinations by 35 months.	• Target will be defined in Year 1 of implementation.	
 Four or more doses of the diphtheria-tetanus-acellular pertussis	U.S.	• 80.7 percent of children born in 2015 received four or more doses of DTaP by their second birthday (IID-06).	• 90.0%	
	USVI	• 60.5% of children aged 19 to 35 months in 2016 (NIS-Child).	• Target will be defined in Year 1 of implementation.	

Objective 1.1.1 Increase rates of recommended vaccinations among young children.				
		Baseline	2030 Target	Strategies
(DTaP) vaccine among children by age 2				

Objective 2.1.2 Increase rates of vaccination among adolescents and adults.				
		Baseline	2030 Target	Strategies
 HPV vaccination among adolescents aged 13 to 15	U.S.	• 48.0% of adolescents aged 13 through 15 years received recommended doses of the HPV vaccine by 2018 (IID-08).	• 80.0%	• Build partnerships with community organizations to promote receipt of recommended vaccinations. • Reduce financial barriers to seeking vaccination. • Develop targeted strategies based on racial and ethnic, age, disability, social, economic, cultural, and other factors that contribute to disparities in vaccination rates. • Expand vaccination sites to non-traditional sites such as pharmacies, OB-GYN practices, other specialty healthcare settings, and non–healthcare settings such as schools, workplaces, places of worship, and community centers. • Promote vaccination as normal and healthy while addressing concerns and dispelling misinformation via social media. • Promote pneumococcal vaccination among adults 65 and older.
	USVI	• No baseline data available.	• Target will be defined in Year 1 of implementation.	
 COVID-19 Vaccination among adults	U.S.	• 38.4% of adults with one dose; 32.7% of adults fully vaccinated (as of June 29, 2021).	• 70% of adults with one dose by July 4, 2021.	
	USVI	• 34.6% of adults with one dose; 28.5% of adults fully vaccinated (as of May 23, 2021).	• Target will be defined in Year 1 of implementation.	
 Pneumonia hospital admission rate among adults 65 or older	U.S.	• 713.9 hospital admissions for pneumonia per 100,000 adults 65 years and older occurred in 2016 (0A-06).	• 642.5 hospital admissions for pneumonia per 100,000 adults.	
	USVI	• No data on hospital admissions is available. • 41.7% of adults 65 or older received the	• Target will be defined in Year 1 of implementation.	

Objective 2.1.2 Increase rates of vaccination among adolescents and adults.				
		Baseline	2030 Target	Strategies
		pneumococcal vaccine in 2016.		

Goal 1.2: Reduce inequities in access to primary and specialty care.

Objective 1.2.1 Increase access to primary care among populations at risk of delaying preventive care.				
		Baseline	2030 Target	Strategies
Prenatal care initiation in first trimester	U.S.	• 76.4 percent of pregnant females received early and adequate prenatal care in 2018 (NVSS-N). • 77.6% of live births occurred to women who received prenatal care in the first trimester.	• 80.5%	• Increase access to telemedicine services. • Enable expansion of clinic hours of primary and preventive care services. • Invest in training and supporting programs with community health workers to increase access to care, improve care navigation, and increase health literacy. • Integrate fire services and emergency medical services to increase access to emergency care. • Develop a coordinated system of care. • Develop pilot programs for targeted groups (e.g., behavioral health, men's health). • Create an integrated system of care for specific groups (e.g., behavioral health, men's health, aging population).
	USVI	• 63.7% of pregnant women received prenatal care in the first trimester in 2017.	• 78.5% (level in 2015).	
No prenatal care	U.S.	• 6.4% of live births occurred to women with no prenatal care in 2019.	• No Healthy People 2030 objective has been established	
	USVI	• 16.6% of pregnant women received no prenatal care in 2017.	• Target will be defined in Year 1 of implementation.	
 Delayed care	U.S.	• 4.1 percent of persons were unable to obtain or were delayed in obtaining necessary medical care in 2017 (MEPS) (AHS-04). • 12.1% of U.S. adults report delaying medical care in the past year (BRFSS).	• 3.3%	

Objective 1.2.1 Increase access to primary care among populations at risk of delaying preventive care.				
		Baseline	2030 Target	Strategies
	USVI	• 21.6% of adults report in the past 12 months that they could not see a doctor when they needed one because of cost (BRFSS). • 16.4% of USVI adults reported delaying medical care in the past year (BRFSS).	• Target will be defined in Year 1 of implementation.	
Health insurance coverage	U.S.	• 89.0% of persons under 65 had medical insurance in 2018 (NHIS) (AHS-01).	• 92.1%	
	USVI	• 81.5% of adults ages 18-64 report that they have any kind of healthcare coverage.	• Target will be defined in Year 1 of implementation.	

Objective 1.1.2 Increase access to specialty care.				
		Baseline	2030 Target	Strategies
 Receipt of specialty treatment for a substance use problem in the past year	U.S.	• 11.1% of persons aged 12 years and over who needed substance use treatment received treatment at a specialty facility in the past 12 months in 2018 (SU-01).	• 14.0%	• Improve data on provider credentials to treat specialized conditions, particularly mental health and substance abuse. • Increase access to specialty and other demand-type providers—conduct assessment to determine provider gaps. • Provider retention and recruitment strategies for pediatric specialty care. • Increase the proportion of children and adolescents with special health care needs who receive care in a family-centered, comprehensive, and coordinated system
	USVI	• No baseline available	• Target will be defined in Year 1 of implementation	
 Availability of pediatric mental health providers	U.S.	• No baseline available	• Not applicable	
	USVI	• There are fewer than 9 psychiatrists practicing in the USVI and few with pediatric credentials.	• Target will be defined in Year 1 of implementation.	

Objective 1.1.2 Increase access to specialty care.				
		Baseline	2030 Target	Strategies
		• There are 16 pediatricians in practice in USVI. • Assessment is needed in this area		
 Availability of services for children with special health care needs	US	• 15.7 percent of children and adolescents under 18 years with special health care needs received care in a family-centered, comprehensive, and coordinated system in 2016-17	• 19.5%	
	USVI	• Baseline not available	• Target will be defined in Year 1 of implementation.	

Priority 2: Chronic Disease Burden

Goal 2.1: Prevent chronic disease among children and adolescents.

Objective 2.1.1 Create healthy eating and safe activity environments for children and adolescents.				
		Baseline	2030 Target	Strategies
 Youth access to unhealthy food and beverages	U.S.	• Increase the proportion of schools that do not sell less healthy foods and beverages (ECBP-D02).	• No Healthy People 2030 objective has been established.	• Train early care and education center professionals to promote consumption of healthy food and beverages and opportunities for physical activity. • Increase access to nutritious and appealing foods and beverages on school campuses. • Provide professional development to school staff on how to incorporate enhanced physical activity programs and policies
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Adolescent	U.S.	• 26.1% of students in grades 9 through 12 were physically active for at least 60 minutes on all 7 days of the	• 30.6%	

Objective 2.1.1 Create healthy eating and safe activity environments for children and adolescents.				
		Baseline	2030 Target	Strategies
physical activity		past week in 2017 (PA-06).		before, during, and after school. • Expand out-of-school programs. • Invest in built environment plans and policies that encourage physical activity. • Implement health community design and land use policies and practices that promote access to physical activity and healthy food. • Improve community access to affordable, preferably locally-grown fruits and vegetables. • Establish policies promoting healthy food environments in schools and early child care centers. • Establish surveillance systems to monitor and track child and adolescent health at the population level.
	USVI	• 20.4% of high school students were physically active for a total of at least 60 minutes per day; 25.1% had no days where they were physically active for a total of at least 60 minutes per day.	• Target will be defined in Year 1 of implementation.	
 Child and adolescent obesity	U.S.	• 17.8% of children and adolescents aged 2 to 19 years had obesity from 2013-2016 (NWS-04).	• 15.5%	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Goal 2.2: Reduce the burden of chronic disease among adults.

Objective 2.2.1 Reduce the burden of metabolic disease and its complications among adults.				
		Baseline	2030 Target	Strategies
 Diabetes incidence	U.S.	• 6.5 new cases of diabetes per 1,000 adults aged 18 to 84 years occurred in the past 12 months as reported in 2016-2018.	• 10-year target: 5.6 new cases of diabetes per 1,000 adults.	• Improve access and quality of prediabetes healthcare delivery. • Develop culturally appropriate prediabetes and diabetes prevention and self-management education programs. • Develop a community-driven wellness plan that includes promotion of healthy living and evidence-based strategies. • Improve data collection and monitoring surveillance
	USVI	• 16.8% prevalence among adults in 2016 (BRFSS).	• Target will be defined in Year 1 of implementation.	
Blood sugar monitoring among	U.S.	• 89.0% of adults aged 18 years and over with diagnosed diabetes using insulin	• 94.4%	

Objective 2.2.1 Reduce the burden of metabolic disease and its complications among adults.				
		Baseline	2030 Target	Strategies
people with diabetes		performed self-monitoring of blood glucose at least once daily in 2017.		systems to monitor and track the health status of adults.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Annual urinary albumin test	U.S.	• 48.7 percent of Medicare beneficiaries with diabetes mellitus had urinary albumin testing in 2016 (D-05).	• 66.6%	
	USVI	• No data available.	• Target will be defined in Year 1 of implementation.	

Objective 2.2.2 Improve adult cardiovascular health.				
		Baseline	2030 Target	Strategies
Obesity prevalence	U.S.	• 38.6% of adults aged 20 years and over had obesity in 2013-16 (NWS-03).	• 36.0%	• Implement policies and programs that increase active transportation and transit use. • Develop and implement culturally diverse territory-wide public service announcements and social media campaigns about resources that address chronic disease. • Plan improvements to the built environment to enable and encourage physical activity. • Implement healthy community design and land use policies and practices that promote access to physical activity and healthy food. • Improve community access to affordable, preferably
	USVI	• 32.2% adult obesity prevalence in 2016.	• Target will be defined in Year 1 of implementation.	
 Coronary heart disease mortality	U.S.	• 90.9 coronary heart disease deaths per 100,000 population occurred in 2018 (HDS-02).	• 71.1 coronary heart disease deaths per 100,000 population.	
	USVI	• 54.9/100,000 (2017-2019)	• Target will be defined in Year 1 of implementation.	
	U.S.	• 29.5% of adults aged 18 years and over had hypertension between 2013-2016.	• 27.7%	

Objective 2.2.2 Improve adult cardiovascular health.				
		Baseline	2030 Target	Strategies
 Hypertension prevalence	USVI	• 26.1% of adults were ever told they had hypertension (2009).	• Target will be defined in Year 1 of implementation.	• locally-grown fruits and vegetables. • Promote adoption of Supplemental Nutrition Assistance Program acceptance by farmer's markets.
Chronic kidney disease prevalence	U.S.	• 14.1% of adults aged 18 years and over had chronic kidney disease between 2013-2016.	• 12.8%	
	USVI	• No data available.	• Target will be defined in Year 1 of implementation.	

Goal 2.3: Reduce mortality associated with cancer.

Objective 2.3.1 Reduce mortality associated with prostate cancer.				
		Baseline	2030 Target	Strategies
 Prostate cancer mortality	U.S.	• 18.8 prostate cancer deaths per 100,000 males in 2018 (C-08).	• 16.9 prostate cancer deaths per 100,000 males.	• Promote early screening of prostate cancer among men according to their age and risk. • Conduct targeted outreach and education to men at high risk for developing prostate cancer.
	USVI	• 26.1% of all cancer deaths were due to prostate cancer; there were 100 prostate cancer deaths between 2003-2013.	• Target will be defined in Year 1 of implementation.	
  Prostate specific antigen testing	U.S.	• 39.0% of men aged 55-69 years had a prostate specific antigen test within the past year.	• No Healthy People 2030 target established.	
	USVI	• 54.3% of men aged 40 and older had a prostate specific antigen test within the past two years.	• Target will be defined in Year 1 of implementation.	

Objective 1.3.2 Reduce mortality associated with breast cancer.				
		Baseline	2030 Target	Strategies
Breast cancer mortality	U.S.	• 19.7 breast cancer deaths per 100,000 females in 2018 (C-04).	• 15.3 breast cancer deaths per 100,000 females.	• Promote mammography among women according to their age and risk. • Increase public and professional awareness about breast cancer inequities in diagnosis and mortality. • Conduct targeted outreach and education to women at higher risk of developing breast cancer.
	USVI	• There were 9 deaths due to breast cancer in 2020	• Target will be defined in Year 1 of implementation	
 Breast cancer screening	U.S.	• 72.8% of females aged 50 to 74 years received a breast cancer screening in 2018.	• 77.1%	
	USVI	• 70.2%% of women aged 50-74 reported they had had a mammogram within the past two years (2016, BRFSS).	• Target will be defined in Year 1 of implementation.	

Priority 3: Behavioral and Mental Health

Goal 3.1: Enhance mental health care infrastructure.

Objective 3.1.1 Improve access and quality of mental health treatment.				
		Baseline	2030 Target	Strategies
Provider capacity to provide integrated behavioral healthcare	U.S.	• Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it (AHS-R01).	• No target has been established for this new Healthy People 2030 objective.	• Attract sufficient mental health professionals to meet the need (with an emphasis on psychiatrists and psychiatric advanced registered nurse practitioners). • Establish residential services within the territory. • Enhance partnership with the National Alliance on Mental Illness chapter and partner with private partners to extend services. • Reconvene the Behavioral Health Advisory Committee
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
	U.S.	• Increase the proportion of public schools with a counselor, social	• No target has been established for this new Healthy People 2030 objective.	

Objective 3.1.1 Improve access and quality of mental health treatment.				
		Baseline	2030 Target	Strategies
 Support capacity of public schools		worker, and psychologist (AH-R09).		for partnership and coordination. (Partnerships exist, but need to be activated.) • Convene the Interdepartmental Behavioral Health Assessment and Transition Teams. • Enhance coordination between hospitals and primary and specialty care for persons with mental health conditions.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
	U.S.	• Increase the proportion of children and adolescents who get appropriate treatment for anxiety or depression (EMC-D04).	• No target has been established for this new Healthy People 2030 objective.	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
Mental health cross-organization coordination	U.S.	• No baseline available.	• Not applicable.	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Objective 3.1.2 Improve quality of mental health early detection and treatment.				
		Baseline	2030 Target	Strategies
Community support	U.S.	• No baseline available.	• Not applicable.	• Provide education and training in mental health first aid, including peer training. • Train private and community health providers on screening for depression and substance abuse.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Early detection	U.S.	• 8.5 percent of primary care office visits included screening for depression in persons aged 12 years and over in 2016 (MHMD-08).	• 13.5%	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Goal 3.2: Address mental health comorbidities, including substance use, chronic disease, and violence.

Objective 3.2.1 Address the interdisciplinary nature of mental health causes and impacts,				
		Baseline	2030 Target	Strategies
 Access to school-based preventive mental health care	U.S.	• Increase the proportion of children and adolescents who get preventive mental health care in school (EMC-D06).	• No target has been established for this new Healthy People 2030 objective.	• Address substance use and its impact on behavioral health by disrupting this pathway in adolescence and youth using evidence-based strategies (pediatric vs. adult). • Develop a multidisciplinary crisis management team trained in de-escalation in the community, provide intervention, linkages to hospitals if needed. • Provide law enforcement with education, resources, protocols regarding behavioral health issues, and crisis and intervention training. • Clarify and strengthen emergency/involuntary hospitalization procedures across governmental and private healthcare organizations. • Enhance referral and follow-up treatment for children and adolescents with trauma-related symptoms. • Improve data collection, analysis and use of evidence-based, culturally relevant interventions for all agegroups.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Access to mental health and substance use treatment among adults	U.S.	• 3.4 percent of adults aged 18 years and over with co-occurring substance use disorders and mental health disorders received both mental health care and specialty substance use treatment in 2018 (HP2030 MHMD-07).	• 8.2%	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Access to treatment for trauma among children and adolescents	U.S.	• Increase the proportion of children and adolescents with symptoms of trauma who get treatment (AH-D02) .	• No target has been established for this new Healthy People 2030 objective.	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
Serious psychological distress among adults	U.S.	• 8.7% of adults with disabilities aged 18 years and over experienced serious psychological distress in 2018 (age adjusted	• 7.6%	

Objective 3.2.1 Address the interdisciplinary nature of mental health causes and impacts,				
		Baseline	2030 Target	Strategies
with disabilities		to the year 2000 standard population) (CH-02).		
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Goal 3.3: Normalize mental health conditions.

Objective 3.3.1 Reduce stigma associated with having mental health conditions and seeking or participating in treatment for mental health conditions.				
		Baseline	2030 Target	Strategies
 Availability of social support to adults	U.S.	• 86.9 percent of adults aged 18 years and over reported having social support (i.e., having friends or family members whom they talk to about their health) in 2017 (HC/HIT-04).	• 92.3%	• Use evidence-based strategies grounded in behavioral health to reduce the stigma of mental health care. • Develop partnerships between schools and community representatives to ensure all children have access to trusted adults. • Develop a public education campaign for mental illness targeting adolescents.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Availability of a trusted adult among adolescents aged 12 to 17	U.S.	• 79.0 percent of adolescents aged 12 to 17 years had an adult in their lives with whom they could talk about serious problems in 2018 (AH-03).	• 82.9%	
	USVI	• No baseline available	• Target will be defined in Year 1 of implementation	

Priority 4: Oral Health

Goal 4.1: Increase capacity to prevent oral health disease.

Objective 4.1.1 Improve primary prevention of oral health disease.

		Baseline	2030 Target	Strategies
Access to fluoridated water	U.S.	• 72.8% of persons were served by community water systems with optimally fluoridated water in 2016 (OH-11).	• 10-year target: 77.1%.	• Develop programs that use evidence-based disease prevention approaches for oral health such as fluoridation, fluoride varnish, and dental sealants. • Increase the health literacy of parents using culturally competent messages that emphasize the importance of early oral health care.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Access to dental sealants	U.S.	• 37.0% of children and adolescents aged 3 to 19 years had received dental sealants on 1 or more of their primary and permanent molar teeth in 2013-16 (OH-10).	• 42.5%	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Objective 4.1.2 Improve oral health workforce and surveillance capacity.

		Baseline	2030 Target	Strategies
Oral and craniofacial surveillance system	U.S.	• Increase the number of states and the District of Columbia that have an oral and craniofacial health surveillance system (OH-D01).	• No target has been established for this new Healthy People 2030 objective.	• Implement a robust oral and craniofacial surveillance system in partnership with dental providers and healthcare providers.

Objective 4.1.2 Improve oral health workforce and surveillance capacity.				
		Baseline	2030 Target	Strategies
	USVI	• No territory-wide oral and craniofacial surveillance system available.	• Implementation of a functioning oral and craniofacial surveillance system.	• Develop programs that promote oral health career opportunities for high school students. • Create and develop a college level dental assistant training program • Develop a liaison between local oral health advocacy groups and local leadership (senators, commissioners, directors, and the executive team) to highlight and prioritize the oral health needs of the territory.
Trained dental health care professionals	U.S.	• No baseline available.	• No established Healthy People 2030 objective.	
	USVI	• There were 78 dentists and 32 dental hygienists with active licenses in 2020 (pg. 30, USVI community health assessment).	• Target will be defined in Year 1 of implementation.	

Objective 4.1.3 Remove barriers to accessing dental services.				
		Baseline	2030 Target	Strategies
 Use of oral health system	U.S.	• 43.3 percent of children, adolescents, and adults used the oral health care system in 2016 (OH-08).	• 45.0%	• Develop and enhance existing programs to promote oral health care, emphasizing community-based approaches. • Create and develop public service announcements using local children or teens to educate and bring awareness about oral health programs, events, and activities in the community. • Develop a policy to expand dental services to high-risk populations. • Promote integration of oral health into other settings, such as community clinics, schools, home visits, nursing homes and telehealth practice. • Simplify the Medical Assistance Program (MAP) approval process. Create
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
Medicaid reimbursement for dental services	U.S.	• No baseline available.	• No established Healthy People 2030 objective.	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
Dental insurance coverage	U.S.	• 54.4% of persons under 65 years had dental insurance in 2018 (AHS-02).	• 59.8%	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Objective 4.1.3 Remove barriers to accessing dental services.				
		Baseline	2030 Target	Strategies
				satellite sites (Christiansted) to access more patients and promote the program for the low income and financially challenged population. Create direct MAP referral for children and elderly patients. • Provide MAP providers with competitive reimbursement and create transparent oversight of the program.

Goal 4.2: Reduce the burden of dental disease

Objective 4.2.1 Reduce active and untreated tooth decay among adults, children, and adolescents.				
		Baseline	2030 Target	Strategies
 Active untreated tooth decay among adults	U.S.	• 22.8% of adults aged 20 to 74 years had active or currently untreated tooth decay in 2013-2016 (OH-03).	• 17.3%	• Create a territory-wide, cross-sector initiative to eradicate early childhood caries. • Create collaborative virtual education programs with the USVI Department of Education and Department of Health and various agencies (e.g., Colgate's Bright Smiles Bright Future program) to educate and give access to young people, families, single parents, educators, and program directors. • Create systems to detect child abuse and child neglect cases based on rampant caries, abscessed teeth, and significant oral trauma in children.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Active untreated tooth decay among children and adolescents	U.S.	• 13.4% of children and adolescents aged 3 to 19 years had active and currently untreated tooth decay in their primary or permanent teeth in 2013-16 (OH-02).	• 10.2%	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Objective 4.2.1 Reduce active and untreated tooth decay among adults, children, and adolescents.				
		Baseline	2030 Target	Strategies
 Moderate and severe periodontitis among adults aged 45 and older	U.S.	• 44.5 percent of adults aged 45 years and over had moderate and severe periodontitis in 2015-16 (OH-06).	• 39.3%	• Create and implement community wellness plans that include oral health promotion.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Children with significant oral health disease and trauma	U.S.	• No baseline available.	• No established Healthy People 2030 objective.	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Loss of all natural teeth among adults aged 45 and older	U.S.	• 7.9% of adults aged 45 years and over had lost all of their natural teeth in 2013-16 (OH-05).	• 5.4%	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Objective 4.2.2 Improve oral health of pregnant women and children under 2.				
		Baseline	2030 Target	Strategies
Periodontal disease among pregnant women	U.S.	• No baseline available.	• No established Healthy People 2030 objective.	• Adopt Protect Tiny Teeth as a part of prenatal care. • Adapt current prenatal health promotion programs targeting health and dental professionals to include training about communicating the safety and importance of dental care during pregnancy and in the neonatal period.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Consumption	U.S.	• 13.5% was the mean percentage of calories from added sugars consumed by persons aged 2 years	• 11.5%	

of sweetened beverages by children aged 2 years and older		and over in 2013-16 (NWS-10).		
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Priority 5: Injury and Violence Prevention

Goal 5.1: Prevent accidents.

Objective 5.1.1 Reduce unintentional injury and death.				
		Baseline	2030 Target	Strategies
Intimate Partner violence		• Non available	• Developmental-a high-priority public health issue that has evidence-based interventions to address it, but doesn't yet have reliable baseline data.	• Reduce intimate partner violence (i.e., contact sexual violence, physical violence, and stalking) across the lifespan by increasing access to evidence-based interventions for all ages
Unintentional injury mortality rate	U.S.	• 48.0 deaths per 100,000 population were caused by unintentional injuries in 2018 (age adjusted to the year 2000 standard population) (IVP-03).	• 43.2 deaths.	• Reduce impaired driving by increasing the use of screening, brief interventions, and referral to treatment in hospitals and primary health settings across the territory. • Increase helmet use among motorcycle and moped riders by supporting universal helmet laws.
	USVI	• 24 people died from unintentional injury in 2016 (Pg.107, USVI CHA).	• Target will be defined in Year 1 of implementation.	
Motor vehicle mortality rate	U.S.	• 11.2 motor vehicle traffic-related deaths per 100,000 population occurred in 2018 (age adjusted to the year 2000 standard population) (IVP-06).	• 10.1 deaths.	

Objective 5.1.1 Reduce unintentional injury and death.				
		Baseline	2030 Target	Strategies
	USVI	• No baseline available, but the overall trend in number of deaths from motor vehicle accidents of all age groups has been increasing—from 4 deaths in 2005 to 11 deaths in 2017.	• Target will be defined in Year 1 of implementation.	

Goal 5.2: Reduce fatal and nonfatal intentional injuries.

Objective 5.2.1 Reduce injuries among children relating to maltreatment.				
		Baseline	2030 Target	Strategies
 Emergency department visits for nonfatal physical assault injuries among children	U.S.	• 511.1 emergency department visits for nonfatal physical assault injuries per 100,000 population occurred in 2017 (age adjusted to the year 2000 standard population).	• 264.1 visits.	• Provide parent education and family supports to strengthen families and reduce social isolation and stressors that may place families at risk for child abuse and neglect. • Screen individuals for domestic violence and refer to domestic violence resources or services by home visiting program personnel.
	USVI	• No baseline available, but the child maltreatment rate in 2015 was 11.0 per 1,000 children under age 18, a decrease from 2013 (13.5 per 1,000 children).	• Target will be defined in Year 1 of implementation.	

Objective 5.2.2 Reduce homicide.				
		Baseline	2030 Target	Strategies
	U.S.	• 25.2 deaths among children and adolescents aged 1 to 19 years per 100,000 population	• 18.4 deaths.	• Establish child fatality review teams to review every death in USVI.

Objective 5.2.2 Reduce homicide.				
		Baseline	2030 Target	Strategies
Child and teen mortality rate due to intentional injury		occurred in 2018 (MICH-03).		• Increase educational attainment and literacy levels. • Screening for domestic violence and referring to domestic violence resources/services in primary care settings to include maternal and child health clinics. • Promote the Strengthening Families cross-sector system to strengthen families' protective factors and mitigate the impact of adverse experiences. • Expand community-based opportunities, such as mentoring, peer support and after-school programs, to build resilience and protective factors among youth. • Promote strategies that enable secure firearm storage. • Provide training and technical assistance to organizations on the implementation of physical and sexual violence prevention strategies.
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Contact sexual assault incidence	U.S.	• Reduce contact sexual violence by anyone across the lifespan (IVP-05).	• No target has been established for this new Healthy People 2030 objective.	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	
 Intentional injury rates, fatal and nonfatal	U.S.	• 70.1 deaths per 100,000 population were caused by injuries in 2018 (age adjusted to the year 2000 standard population) (IVP-01).	• 63.1 deaths per 100,000.	
	USVI	• No baseline available.	• Target will be defined in Year 1 of implementation.	

Priority 6: Public Health Infrastructure

Goal 6.1: Develop and sustain a five-year health planning process.

Objective 6.1.1: Strengthen health system planning and partnerships.			
2030 Target	Current Status and Assets	Desired Result	Initial Strategies
Functioning, sustainable health planning	• Completed community health assessment in 2020.	• Completed CHIP report. • Implementation plans and performance monitoring system for CHIP. • Sustainable process for health planning in a five-year cycle.	• Engage ASTHO and other experts for support and guidance to develop a sustainable health planning system and process. • Create a permanent health planning team and leadership charge to conduct planning.
Healthcare facilities	• Healthcare facilities in various stages of disrepair and/or development.	• State of the art healthcare facilities (including primary, secondary, and tertiary care facilities).	• Assess the need for healthcare facilities to meet current and future population healthcare needs. • Continue progress on plans to repair damaged facilities. • Conduct repairs and construction of facilities.
Quality improvement systems	• Limited quality improvement as a way to increase efficiency and effectiveness in the USVI DOH.	• Established quality improvement processes and adoption of quality improvement into the culture of USVI DOH.	• Participate in quality improvement training at all levels of USVI DOH. • Develop a quality improvement plan.

Goal 6.2: Develop public health infrastructure and service capacity.

Objective 6.2.1: Strengthen health system planning and partnerships.			
2030 Target	Current Status and Assets	Desired Result	Initial Strategies
Increase laboratory diagnostic testing capacity, surveillance, and reporting	• Some laboratory diagnostic testing capacity. • Gaps in surveillance and reporting.	• Larger capacity for laboratory diagnostic testing. • Gaps in surveillance and reporting.	• Assess current public health laboratory capacity. • Identify laboratory service needs.
Maintain healthcare facilities with no disrepair that impedes or limits the expansion of patient care services	• Healthcare facilities in various stages of disrepair and/or development.	• State of the art healthcare facilities (include primary, secondary, and tertiary care facilities).	• Assess need for healthcare facilities to meet current and future population healthcare needs. • Continue progress on plans to repair damaged facilities. • Conduct repairs and construction of facilities.
Increase the number of programs aimed at improving health in people with disabilities	• Limited number of programs.	• Programs on every island that meet the needs of people with disabilities.	• Conduct assessment of current programs aimed at improving health in people with disabilities. • Identify gaps in services by age and develop targeted strategies to improve health. • Develop and implement plans to address gaps in services.

Objective 6.2.2: Increase skills of the public health workforce.			
2030 Target	Current Status and Assets	Desired Result	Initial Strategies
Increase the number of individuals trained globally to prevent, detect, or respond to public health threats	• This objective is developmental and will be assessed in the first year of CHIP implementation.	• Increase in the number of individuals trained to prevent, detect, or respond to public health threats.	• Assess the current level of trained individuals. • Identify gaps in training. • Develop or identify appropriate training programs to fill gaps. • Develop and implement a comprehensive training plan. • Monitor the number of individuals trained to prevent detect or respond to public health threats.

Objective 6.2.2: Increase skills of the public health workforce.			
2030 Target	Current Status and Assets	Desired Result	Initial Strategies
Increase the use of core public health competencies in continuing education for the USVI public health workforce	• This objective is developmental and will be assessed in the first year of CHIP implementation.	• Increase in the use of core public health competencies in continuing education for the public health workforce	• Assess current use of core public health competencies in continuing education for the USVI public health workforce. • Identify gaps in use of core public health competencies in continuing education for the USVI public health workforce. • Develop a comprehensive plan to increase the use of competencies. • Ensure implementation of the plan. • Monitor use of the core public health competencies in continuing education for the USVI public health workforce.
Explore public health pipeline programs to include service or experiential learning	• University of the Virgin Islands School of Nursing students rotate through hospitals and public health clinics as part of course of study to earn the BSN degree.	• Implementation of at least two public health pipeline programs to increase service or experiential learning.	• Identify pipeline programs that may be suitable for the territory. • Partner with the University of the Virgin Islands to develop a plan for undergraduate and graduate students. • Partner with the USVI Department of Education to explore pipeline programs for middle and high school students.

Objective 6.2.3: Improve health data and informatics.			
2030 Target	Current Status and Assets	Desired Result	Initial Strategies
Increase the use of health informatics in the public health system in USVI	• Health data systems are partially manual and not interconnected electronically.	• An integrated health data system that includes broad implementation of telehealth and telemedicine platforms.	• Convene a data users group with representation across key agencies and communities. • Assess current data systems and their use that enables future assessment of programs. • Identify gaps in current data systems and develop and implement a comprehensive plan to create an integrated health data system

Objective 6.2.3: Improve health data and informatics.			
2030 Target	Current Status and Assets	Desired Result	Initial Strategies
			inclusive of telehealth and telemedicine systems.
Increase the proportion of people with vaccination records in an information system	• The immunization registry is in final stages of revitalization.	• A fully functional immunization registry.	• Continue efforts to rebuild the immunization registry. • Identify resource needs to ensure the immunization registry is fully functional. • Ensure that the immunization registry has redundant backup systems. • Launch the immunization registry.
Implement the standard module on sexual orientation and gender identity in the Behavioral Risk Factor Surveillance System	• This objective is developmental and will be assessed in the first year of CHIP implementation.	• Adoption of standard module on sexual orientation and gender identifies included in Behavioral Risk Factor Surveillance System.	• Convene a data users group with broad representation across agencies and the community. • Ensure that this module is included in the Behavioral Risk Factor Surveillance System. • Disseminate findings from the Behavioral Risk Factor Surveillance System to the public.

Implementation

Implementation

Health improvement is intended to be iterative, where process and outcomes are examined for their effectiveness and course correction is applied where appropriate. This focus on quality improvement should be continuous and embedded in health planning. However, this shift toward quality improvement is an adjustment and requires time and training. USVI DOH is committed, as part of its strategic plan, to create an organizational culture where decisions are driven by data and evidence and quality improvement is at the top of the public health toolbox.

The development and implementation of the CHIP is a collaborative effort between community partners and USVI DOH, with the health agency playing the roles of leader and convener of partners. This health planning process is USVI's first in over a decade, and it will be the first cycle of health planning to apply the MAPP framework as part of a coordinated, collaborative effort. Bumps in the road are anticipated and welcomed as opportunities for learning and growth as the partnership between the health agency and the community deepens through this improvement initiative. As part of USVI DOH's organizational growth, it is expected that the CHIP will lead to the development of a quality improvement plan that will set the stage for USVI's next cycle of health assessment and improvement planning. Community partners are invited to contribute their experience and expertise to help improve the quality of health improvement work in USVI.

Improvement in a Time of Pandemic

In early 2020, USVI began shifting resources toward its response to the emerging COVID-19 pandemic, rapidly developing emergency procedures and policies to prevent the spread of SARS-CoV-2 and instituting a data tracking system to get out information to the public. The agency created and implemented a large number of public health directives in the span of a few months to ensure public safety. These included deploying targeted public health information, collaborating with government agencies and organizations to develop appropriate policy, implementing contact tracing and testing sites, and supporting Virgin Islanders in adopting measures such as social distancing, mask wearing, and quarantine. These efforts were complemented by an unprecedented transparent deployment of pandemic-related data to the community at large.

As we emerge on the other side of this pandemic, we have learned that we are capable of adapting to extraordinary circumstances. We learned from our hurricane recovery work that partnerships and building trust with the community are foundational activities in public health. We also learned that much of what we assessed in our community health assessment in 2020 may not be the true baseline for our improvement work. In fact, that baseline may be worse, as the pandemic only made more obvious to us the existing health inequities in our communities. The good news is that we learned we can move swiftly to respond to emergencies, and we can do so while responding to the emergency of inequitable health for our most vulnerable residents.

Immediate Next Steps

In the first year of our CHIP, we plan to undertake change and begin early implementation. Our immediate next step is to develop action plans for each priority area. In its role as leader and convener of this process, USVI DOH's CHIP team will provide project management to ensure implementation of each health priority action plan. Each priority area will have a designated leader responsible for implementing the area's overall action plan, and each area will have action planning teams for each goal of that priority to carry out implementation, monitor progress toward goals, and mitigate challenges for their assigned goals.

The first step for each action plan is to develop an implementation work plan with clear milestones. These work plans will be approved by the USVI DOH CHIP Steering Committee, which will develop a quarterly meeting schedule to facilitate routine monitoring of CHIP implementation. The committee will assess progress toward the desired outcomes for each priority area and ensure community engagement throughout implementation.

Transparency during implementation is essential to ensure community engagement and input throughout the process. The CHIP DOH team will develop quarterly and annual reports about progress in each action plan that will be posted on the USVI DOH website. Action teams will also hold community forums periodically to share progress with the community.

Performance monitoring and evaluation will be conducted by the CHIP DOH team. USVI DOH will consider creating a public dashboard showing progress toward key metrics in the CHIP. If feasible, USVI may engage an external evaluator to assess the implementation of the CHIP and to develop recommendations for improvement during its next improvement cycle. The work plan below presents the high-level steps that Healthy Virgin Islands 2030 intends to achieve in its first year.

Activity	Months
USVI DOH identifies a lead for each priority area and recruits members of each priority area action planning team.	1
USVI DOH convenes action planning teams for each goal and refines metrics and targets.	2-3
Action planning teams develop a health priority action plan (implementation work plan) for each priority area goal.	4-6
CHIP Steering Committee reviews and approves health priority action plans.	7-8
USVI DOH commissioner and executive committee review and approve health priority action plans.	6-9
USVI DOH develops a performance monitoring and evaluation plan.	9
Action planning teams begin implementation.	9-12
USVI prepares and publishes a first-year progress report.	12

Appendices

Appendix A

U.S. Virgin Islands Community Health Improvement Plan Steering Committee Charter

Purpose

This charter outlines the aim and strategies of the U.S. Virgin Islands (USVI) Community Health Improvement Plan (CHIP) Steering Committee (SC) in our effort to improve the health of all Virgin Islanders. The USVI CHIP SC is a subcommittee of a larger health planning initiative led by the USVI Department of Health (DOH) to achieve a vision of creating a trusted system that supports a healthy USVI. The committee includes partners from many sectors that pledge to collaborate in planning this cross-sector improvement work for the Healthy Virgin Islands 2030 initiative.

Primary Role and Responsibilities

The primary role of USVI CHIP SC is to develop a written community health improvement plan by the end of June 2021 that identifies three to five health priorities through a process informed by the 2020 community health assessment and meaningful, authentic input from the USVI community at large. Each committee member is responsible for:

- Participating in a series of meetings to identify these priorities and strategies.
- Contributing to and reviewing the written CHIP.
- Actively engaging the communities that they represent to ensure those voices are heard and elevated throughout this work.

USVI CHIP SC is not charged with implementing, monitoring, or evaluating the CHIP but is invited by USVI DOH to participate in and amplify those efforts once the written CHIP is finalized and shared with the community.

USVI CHIP SC embraces the values that underpin this initiative, including:

- Equity
- Results-Oriented Performance
- Community-Focused
- Integrity
- Compassion
- Accountability
- Teamwork
- Inclusiveness & Respect

Our Aim and Approach

USVI CHIP SC, in consultation with the community, will create a CHIP that will work toward creating a trusted public health and healthcare system for all Virgin Islanders. Using an adaptation of the Mobilizing for Action through Planning and Partnerships model for community health improvement, USVI CHIP SC will achieve this aim by:

- Reviewing key gaps and limitations in the public health system and inequities in USVI health outcomes and communicating this assessment to the community to enhance its understanding of population health.
- Identifying, in consultation with our community, three to five health priorities that will reduce health risks, improve access to high quality healthcare services, and enforce health standards across USVI.
- Developing a written CHIP that includes priority-based strategies for achieving measurable outcomes by the end of 2024.
- Creating a process to implement priority-based teams that will develop priority-area action plans based on the strategies presented in the CHIP.
- Developing procedures to monitor and adjust implementation of the priority-area action plans.
- Developing a plan to evaluate our improvement effort for future learning and health planning.

Measuring Success

USVI CHIP SC will propose indicators that enable monitoring of the CHIP in alignment with USVI DOH key performance indicators. These indicators will be detailed, measurable outcomes and targeted thresholds that will signal that success has been achieved within each priority area.

Appendix B

Steering Committee Membership

U.S. Virgin Islands Department of Health

Justa Encarnacion, Commissioner
Nicole Craigwell-Syms, Assistant Commissioner, Management and Operations
**Janis Valmond, Deputy Commissioner, Health Promotion Disease Prevention
Tai Hunte-Caesar, Medical Director
**Donna Christensen, Public Health Advisor
Shanna O'Reilly, Chief of Staff
**Berlina Wallace-Berube, Director, Primary Care Office

Office of the Governor of the U.S. Virgin Islands

Julia Sheen, Policy Advisor
Julien Henley Sr., Territorial ADA Coordinator for the U.S. Virgin Islands

Office of Senator Novelle Francis

Shawna Richards, Chief of Staff

Gov. Juan F. Luis Hospital and Medical Center

Dyma Williams, Acting CEO
Hazel Philbert, Chief Operating Officer

USVI Department of Human Services

Kimberly Causey-Gomez, Commissioner
Michelle M. Francis, Director of Strategic Planning and Operations
Gary Smith, Director, Medical Assistance Program

Frederiksted Health Care, Inc.

Masserae Sprauve Webster, CEO
Camille Paul, Physician Assistant

St. Thomas East End Medical Center Corporation

Moleto Smith, Executive Director
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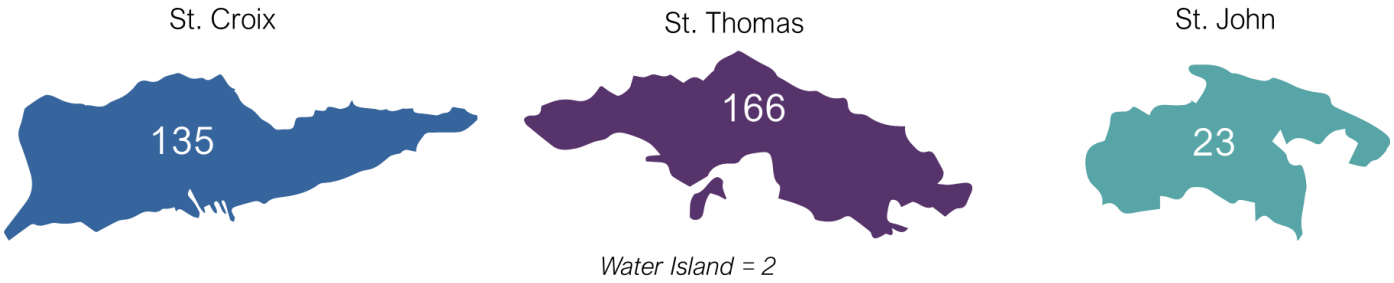
[1] **VIDOH Core Planning Team

Appendix C

Summary of Community Survey Results

Response Rate and Characteristics

A total of 557 individuals responded to the community survey over a six-week period between mid-February and March 2021. Among the 326 survey respondents who indicated their island of residence, the majority were from St. Thomas (166 or 51%).

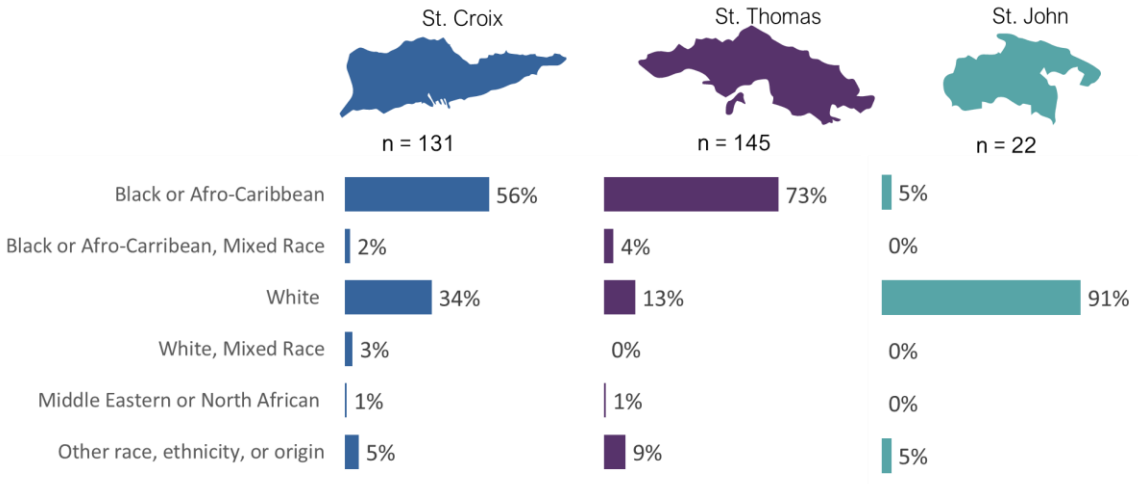


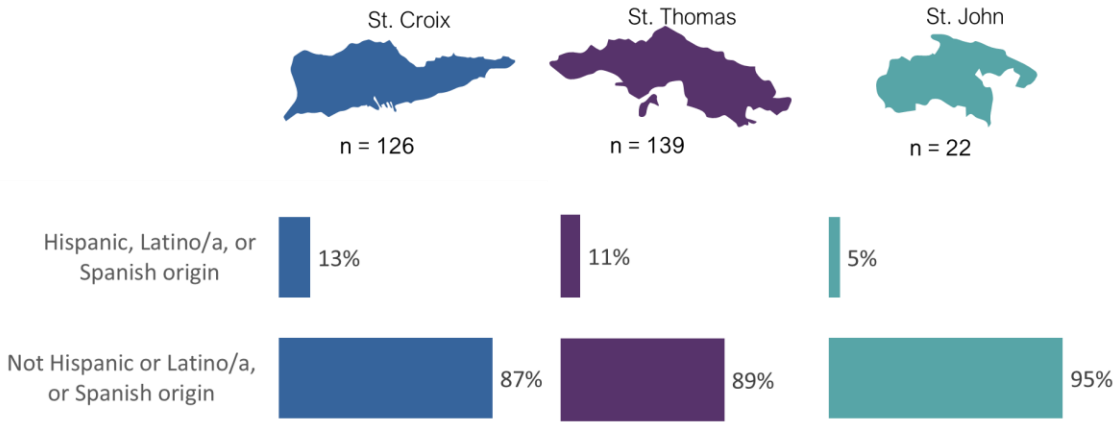
82% Female

78% Female

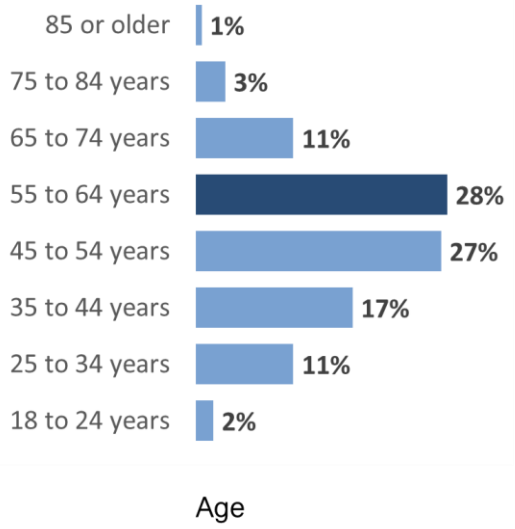
87% Female

A majority (63%) of respondents to the survey identified as Black or Afro-Caribbean if they resided on St. Croix or St. Thomas. Almost all respondents from St. John (91%) identified as White. A majority (89%) of respondents to the survey did not identify as Hispanic.

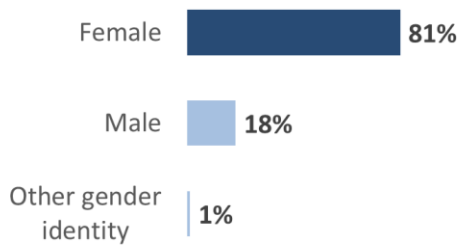




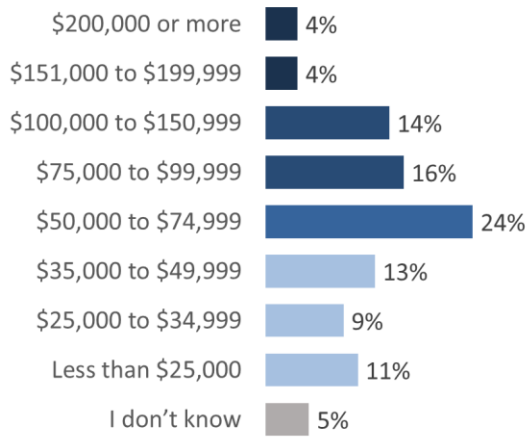
Most (27%) respondents identified their age as being 45 to 64 years, and most (81%) respondents indicated they were female and had an income between $50,000 and $74,999 (24%). Most respondents (59%) reported having full-time, year-round employment. Almost all (96%) respondents spoke English as a primary language, and most (83%) respondents held a high school diploma or had completed some graduate schoolwork or degree. A small percentage (19%) of respondents were healthcare professionals.



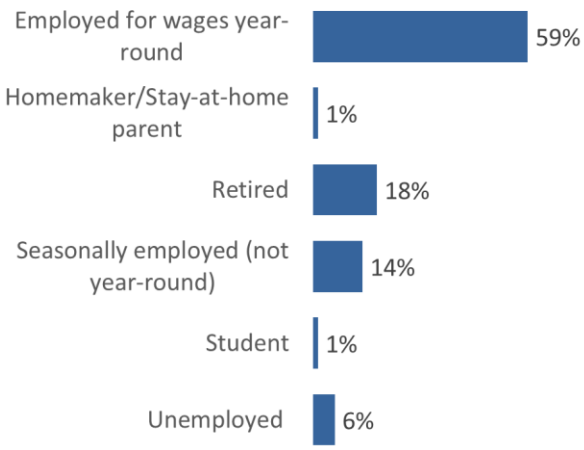
Age



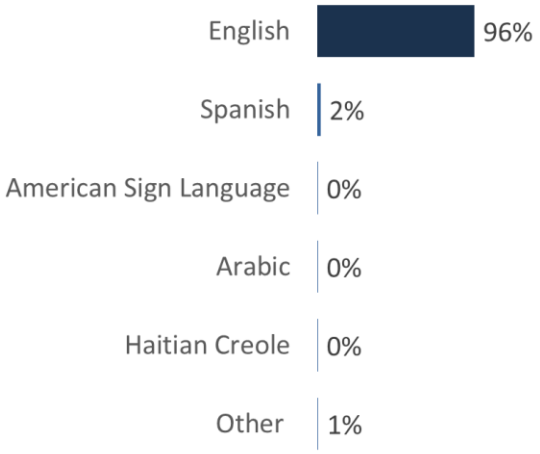
Gender



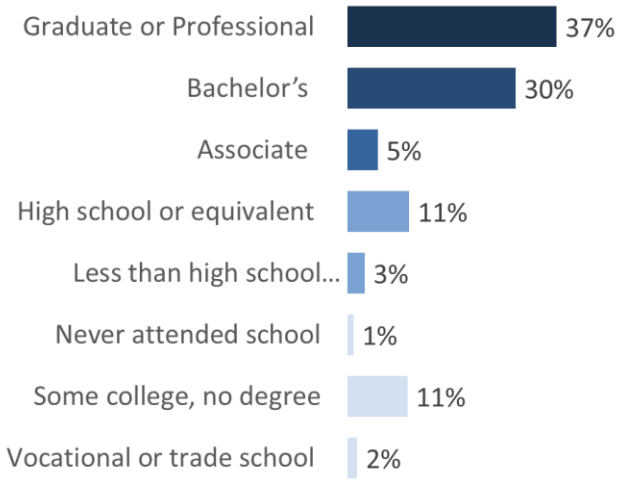
Household Income



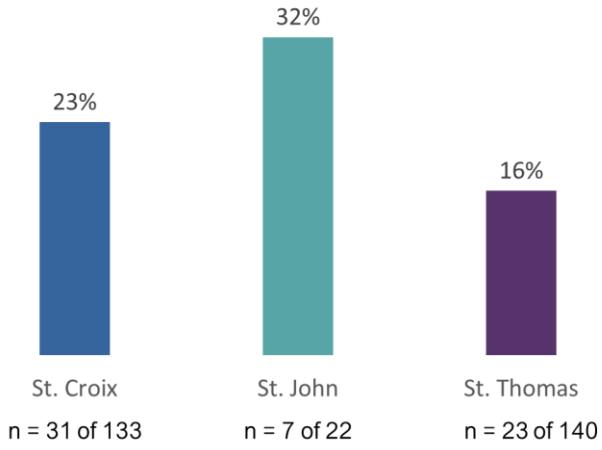
Employment Status



Primary Language



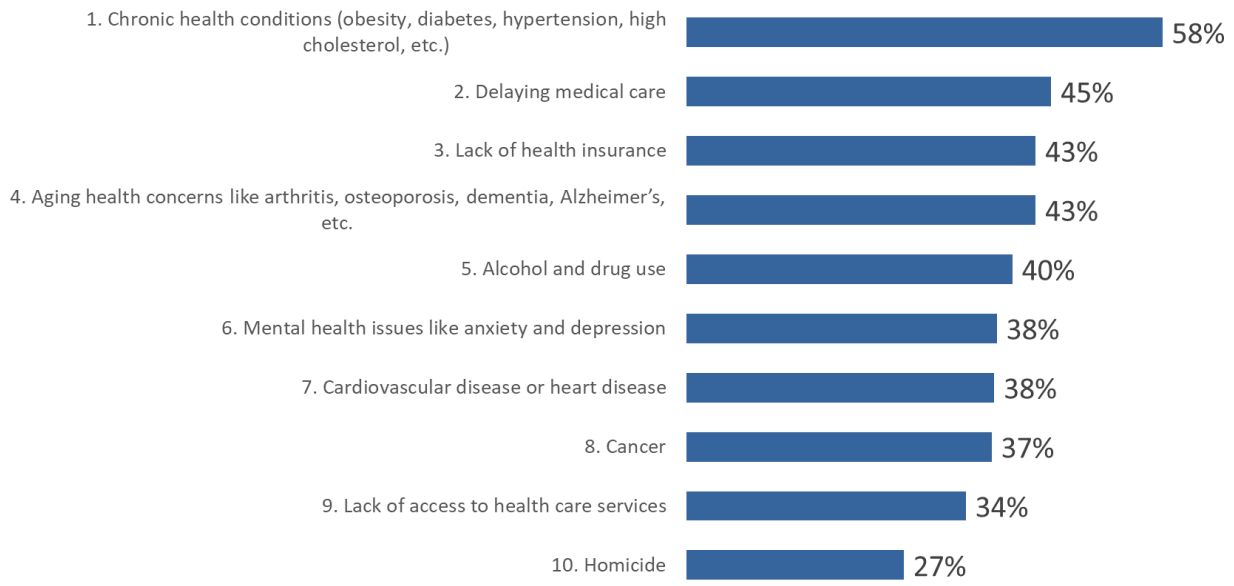
Highest Education



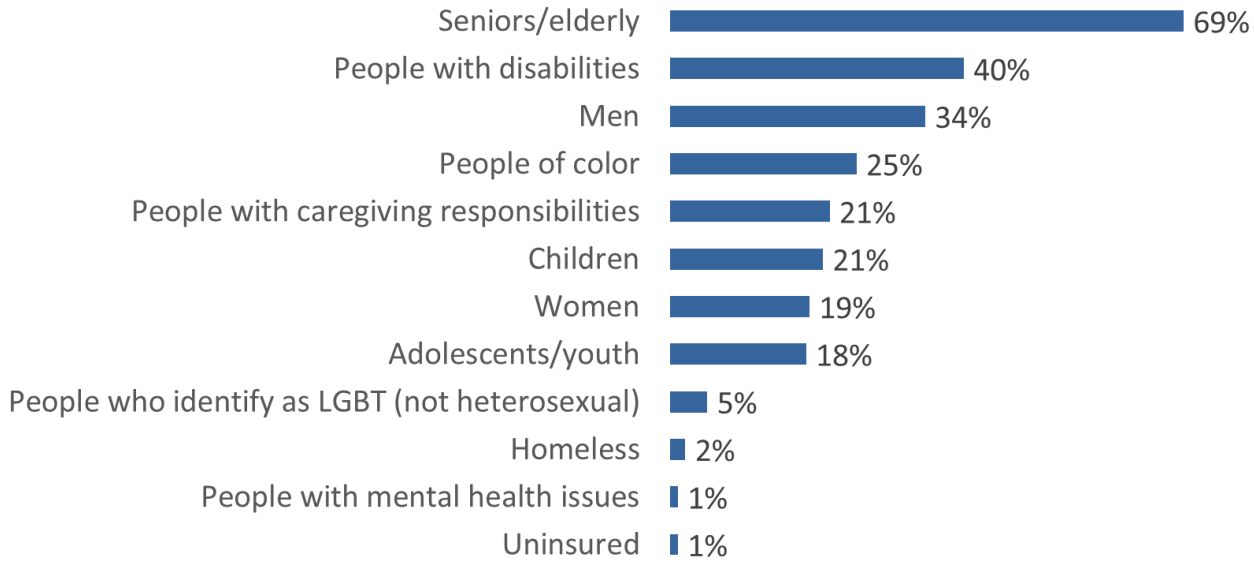
Health Care Provider

Health Priorities

When asked what were the most important health challenges facing people living in their community, a majority of respondents (58%) chose chronic health conditions (obesity, diabetes, hypertension, high cholesterol, etc.) as their top challenge. Delaying medical care and not having insurance were also among the respondents' top challenges.



Respondents also named seniors as their top population of concern, followed by people with disabilities and men.



When asked about pressing health issues besides COVID-19, a quarter or more of respondents identified diabetes and access to care as important to them.