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2019-2020 Needs Assessment of the USVI's ECE Mixed-Delivery System

Caribbean Exploratory Research Center
University of the Virgin Islands

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A NEEDS ASSESSMENT OF THE AVAILABILITY AND QUALITY OF PROGRAMS IN THE USVI EARLY CHILDHOOD CARE AND EDUCATION (ECE) MIXED DELIVERY SYSTEM (MDS) FOR CHILDREN BIRTH THROUGH FIVE (B-5) FROM VULNERABLE FAMILIES

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ABBREVIATIONS AND ACRONYMS

A

ACA……Affordable Care Act
ACASI……Audio Computer Assisted Self Interview Software
ACF …… Administration for Children and Families
ACT……American College Testing
AIA ……Amended Interagency Agreement
ASQ …… Ages & Stages Questionnaires
ASQ:SE……Ages & Stages Questionnaires: Social-Emotional Development Screening Tool

B

BHADDS……Behavioral Health, Alcoholism, and Drug Dependency Services

C

CBO……Community-based Organization
CCRP……Child Care Research Partnership
CERC …… Caribbean Exploratory Research Center
CHIP……Children's Health Insurance Program
CLASS……Classroom Assessment Scoring System
CNA …… Community Needs Assessment
COR ……Child Observation Record
CSHCN……Children with Special Health Care Needs

D

DHHS……Department of Health and Human Services
DLL……Dual Language Learners
DOSE……District Office of Special Education

E

ECAC……Early Childhood Advisory Committee
ECDC……Early Childhood Data Collaborative
ECE …… Early Childhood Care and Education
ECER-S……Early Childhood Environment Rating Scale
ECIDS……Early Childhood Integrated Data System
ECTI ……Early Childhood Transition Infrastructure
ED……U.S. Department of Education
EF……Executive Function
EHS …… Early Head Start
ESL……English as a Second Language

F

FAPE……..…….……..Free and Appropriate Public Education
FEMA……..…Federal Emergency Management Agency
FFNs…….……Family, Friends, and Neighbors
FHC..……..……...……Frederiksted Health Care, Incorporated
FORHP……...Federal Office of Rural Health Policy
FQHC ……..……..…….…….. Federally Qualified Health Center

G

GPP……..……Granny Preschool Program

H

HCVP ……..……..…… Housing Choice Voucher Program
HHS……..……Department of Health and Human Services
HRSA ……..…….. Health Resources and Services Administration
HS ……..……..……... Head Start
HSITC……..HighScope Infant-Toddler Curriculum
HSPC……..……HighScope Preschool Curriculum

I

IA……..……..Interagency Agreement
ICF ……..……..……..…….Informed Consent Form
IDEA……..……Individuals with Disabilities Education Act
IES……..……..……Institute of Education Sciences
IEP……..……..……Individualized Education Plan
IFSP……..……..……..Individualized Family Service Plan
IPV……..……..……..……Intimate Partner Violence
IRB ……..……..…… Institutional Review Board
ITP ……..……..……Infant and Toddlers Program

J

JAG……..……..……Jobs for America's Graduates
JOBS……..……Job Opportunities and Basic Skills

K

KI ……..……Key Informant

L

LAP – 3 ……..…….Learning Accomplishment Profile Third Edition
LEA ……..……..….Local Education Agency
LRE……..……..…..Least Restrictive Environment
LSSVI ……..……..……..…… Lutheran Social Services of the Virgin Islands

M

MAP……..……..……..Medical Assistance Program
MCH……..……..……..…… Maternal and Child Health
MCT ……..……..……..……Mississippi Curriculum Test
MDS……..……Mixed Delivery System
MIECHV……..……..……Maternal Infant and Early Childhood Home Visiting Program
MOA ……..……..……. Memorandum of Agreement
MOU……..……..Memoranda of Understanding

N

NICHD……..……..……..……National Institute of Child Health and Human Development
NGO……..……..……Non-governmental organizations

O

OCCRS……..……Office of Child Care and Regulatory Services
OMB……..……..……Office of Management and Budget
OPRE…… Office of Planning, Research and Evaluation
OSEP……..……..……Office of Special Education Programs

P

PAOS……..……..……Partner Agencies and Organizations
PDG B-5……..……Preschool Development Grant Birth through Five
PH……..……..……..Public Housing
PIR ……..……..…… Program Information Report
PPEP……..……..…Program Performance Evaluation Plan
PPS……..……..……Probability Proportionate to Size
PROCOM……..……..……Project Committee

Q

QRIS……..……..……..Quality Rating and Improvement System

S

SAC …….……..…….……. State Advisory Council
SECC……..……Study of Early Childcare
SLDS……...State Longitudinal Data System
SNAP ……..……...…..…..…… Supplemental Nutrition Assistance Program
SOSE……...State Office of Special Education
STEEMCC …….……..…..…..…..… St. Thomas East End Medical Center Corporation

T

TANF …… Temporary Assistance for Needy Families

U

UDS ……..…….. Uniform Data Set
US……..……..……..United States
USVI ……..……..…….United States Virgin Islands
UVI……..……..……University of the Virgin Islands

V

VICS ……..…… Virgin Islands Community Survey
VIDE……..……Virgin Islands Department of Education
VIDHS ……..……..……..Virgin Islands Department of Human Services
VIDOH ……..……..……Virgin Islands Department of Health
VIHA ……..……..……..…… Virgin Islands Housing Authority
VIUCEDD…..……Virgin Islands University Center for Excellence in Developmental Disabilities
VIS2Q ……..……Virgin Islands Steps to Quality
VIVIS……..……..……Virgin Islands Virtual Information System

W

WIC ……..……...…..Women, Infants, and Children
WIDA……..……. World-Class Instructional Design and Assessment

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EXECUTIVE SUMMARY

INTRODUCTION

The Preschool Development Grant Birth through Five (herein after, PDG B-5), was awarded to the V.I. Department of Human Services (VIDHS) as a one-year, federally funded project, *Road to Success: Developing an early child care and education mixed delivery system for the B-5 population in the USVI.* The project was implemented under the direction of the University of the Virgin Islands' Caribbean Exploratory Research Center (UVI CERC), which served as the designated State Entity. The project, funded by the Administration for Children and Families Office of Child Care, sought to develop a comprehensive strategic plan for a mixed-delivery system as a critical step towards strengthening and improving early childhood care and education (herein after, ECE) in the U.S. Virgin Islands (USVI). As a preliminary step to inform the development of the strategic plan, UVI CERC, as the State Entity, spearheaded the completion of a comprehensive Needs Assessment of the current B-5 ECE mixed delivery system in the USVI. The information presented will inform the development of the USVI's PDG B-5 Strategic Plan which will delineate the Territory's roadmap for developing and sustaining a high quality, mixed delivery B-5 ECE system in the Territory

METHODOLOGY

To complete the Needs Assessment, the research team used a concurrent, mixed-methods design (Creswell, 2009). Primary data collection included the collection of quantitative (survey) and qualitative (key informant interviews, focus group discussions, and town hall meetings) methods. Secondary data were also a critical component of data collection and included the collection of administrative data, programmatic reports from relevant agencies, and census-related data.

Seven specific aims guided the completion of the Needs Assessment: describe the B-5 population in the USVI based on key demographic variables; describe the current ECE programs and services available for B-5 children and their families in the USVI; describe the curriculum and assessment systems in place in the ECE programs in the USVI; describe gaps and barriers in ECE programs and services in the Territory; describe the quality of ECE programs and services currently available to B-5 children and their families; document perceptions of parents/guardians whose children attend ECE programs in the Territory; and document funding available for existing ECE programs and services in the Territory.

NEEDS ASSESSMENT PARTICIPANTS AND DATA COLLECTION

Over 550 persons on the islands of St. Croix, St. John, and St. Thomas participated in data collection activities in support of the Needs Assessment of the Territory's Early Childhood Care and Education (ECE) mixed-delivery system (MDS). This included participation in Town Hall meetings, focus group discussions, key informant interviews, and parent, caregiver/teacher, inclusion, transition, and general stakeholder surveys. Participants included Head Start and Early Head Start parents and teachers; childcare center caregivers; pre-school teachers from private and parochial schools; and Granny Preschool and kindergarten teachers from the public elementary schools across the Territory. Additionally, persons providing

support services in these settings, first grade teachers, school counselors and administrators, and persons working in other early care settings completed a general stakeholder survey. Persons from Head Start, Early Head Start, and the V.I. Department of Education who participate in the transitioning of children from Early Head Start to Head Start; Head Start to kindergarten; and/or from the Part C program to Part B were invited to complete a transition survey. State Advisory Council members completed an inclusion survey.

KEY FINDINGS

The USVI Context

- The USVI is a group of small islands in the northeastern corner of the Caribbean archipelago with a declining and aging population that is predominantly of African descent, multi-racial, multi-ethnic, and linked genetically and culturally to the Caribbean and the US.
- The USVI population faces stressors associated with high levels of unemployment, relatively low educational attainment, and persistent, pervasive poverty.
- Currently the USVI Government and people are confronting the challenges associated with a financial deficit and the need to address the demands of recovery to the infrastructure, elements of the economic base, and public health conditions from the damages and disruption of Category 5 hurricanes Irma and Maria in 2017.
- Weaknesses in the USVI economy, infrastructure and community health and education systems have been additionally stressed by the need to respond to the COVID19 pandemic.

The USVI B-5 Population

- The USVI birth to age five population is predominantly of African descent, multi-racial and multi-ethnic, with the majority born in the USVI.
- The development, health, and care of children in the USVI birth to five population are heavily impacted by poverty, limited access to health insurance, and the challenges associated with living in households predominantly headed by single-females.

Early Care and Education Programs and Services: Who is being served?

It is important for policymakers and other decision makers to have a complete picture of who receives specific services or whether those services promote school readiness and/or positive health outcomes for children B-5 from vulnerable families. Based on the secondary and administrative data available for children and families being served or awaiting service in the USVI ECE MDS, the findings of this Needs Assessment showed that:

- Agencies and programs that serve children B-5, such as HS, EHS, affordable public housing, WIC, MAP, FQHCs, collect a wide range of data; however, these data are delineated differently, mainly for compliance reporting.
- Programs and services face challenges in collecting and sharing current, complete and reliable data to better understand the ECE system and to determine if and where additional early childhood program investments are needed. The challenges are due, in part, to the lack of human resources, technical capacity and clear policies/agreements to facilitate cross-agency data sharing.
- The USVI is in the process of expanding its capacity to link child-, family-, and program-

level data across ECE programs. The Virgin Islands Virtual Information System (VIVIS) cannot yet link child-, family-, and program-level data. However, through the Early Childhood Integrated Data Systems (ECIDS), efforts are underway to enhance the system to facilitate the provision of unduplicated data on children B-5.

- Due to data limitations, it is difficult to know whether ECE services are equitable and responsive to the diverse needs of vulnerable families in the Territory because many programs do not maintain a record of unduplicated counts of beneficiaries and persons awaiting services across ECE programs and systems.

Systems and Partner Collaborations and Supports

- The key agencies that support ECE programs in the Territory – VIDHS, VIDOH, VIDE, and LSSVI report a range of formal collaborations across agencies as well as with other entities and providers to meet mission-critical outcomes, to include feeding (WIC agreements with HS and EHS); health screenings for HS children (VIDHS and FQHCs); primary care to the uninsured and children in need of immediate medical assessments (LSSVI-EHS and Pediatric Care Center of the VI).
- Informal collaborations and partnerships also exist between and among agencies providing direct and support services to the B-5 population (VIDE Granny Preschool Program (GPP) and VIDHS HS to reduce the number of children on the HS waiting list by enrolling them in the GPP; and VIDHS with EHS relative to data and recruitment).
- Notwithstanding existing collaborations and partnerships, there was a recognition, based on qualitative data collected that additional and expanded collaborations are needed, particularly between VIDHS OCCRS and private licensed childcare facilities to optimize outcomes for B-5 children and their families.

Quality and Availability of Programs and Supports

- The VIDHS licenses and monitors the Territory's private, organization-based, and church-based childcare facilities pursuant to regulations set forth in the Rules and Regulations for Childcare Facilities, After School Programs, and Summer Camps. Enrollment capacity and accommodation for infants and toddlers differ by district.
- To address *high-quality care and education,* the Territory developed a graduated quality standards program - Virgin Islands Steps to Quality (VIS2Q), based on the Quality Rating and Improvement System (QRIS). The VIS2Q has not been fully implemented.
- Territory-wide, the Temporary Assistance to Needy Families (TANF) program provides support to qualified families for job training and placement. The effectiveness of the program is challenged by difficulty identifying job opportunities for TANF clients, and the lack of consistent availability of needed transportation to support parents.
- The VIDHS coordinates with the Virgin Islands University Center for Excellence in Developmental Disability (VIUCEDD), the Virgin Islands Department of Education (VIDE) – State Office of Special Education (SOSE), and the Department of Health (VIDOH) - Infants and Toddlers Program (Part C) to identify children who are developmentally delayed and connect them and their families to needed services. The VIDE administers the Individuals with Disabilities Education Act (IDEA) Part B (Preschool Special Education), and the VIDOH administers Part C.
- Programs/supports available to vulnerable or underserved children and families include

the Medical Assistance Program (MAP), Child Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), the Women, Infants and Children Program (WIC), and the national school lunch and breakfast programs (VIDE).

- There is limited access to pediatric health care providers in the areas of dental and behavioral health services, as well as many specialty areas.

Indicators of Progress

- Two key indicators of progress are addressed in this Needs Assessment – the Territory's Quality Improvement Rating System (QRIS) – V.I. Steps to Quality (VIS2Q) and assessment data for children B-5.
- Though the Territory has developed and piloted a QRIS (VIS2Q), currently, VIS2Q has not been fully implemented since the pilot study was completed. VIDHS is currently fine-tuning VIS2Q and plans are underway to implement the quality rating system in the near future.
- EHS utilizes the ASQ, HS utilizes the COR and LAP-3, and VIDE utilizes i-Ready and LAP-3 to assess children's progress with respect to developmental milestones as well as other critical domains related to the COR curriculum used in HS and EHS.
- Both COR data and LAP-3 data reveal that HS children across the Territory are not making the targeted progress in the language and literacy and cognitive domains.
- LAP-3 data collected during the Kindergarten year reveal that children whose early care and education (ECE) occurred in a licensed, private setting performed better in the language and literacy and cognitive domains than did children whose ECE foundation was HS or FFN settings, and children whose ECE foundation was HS performed better than those from FFN settings.
- Though owners/operators and administrators of licensed childcare facilities provided information on how they address children's progress, currently, there is no repository which houses these data.

Transition Supports

- There are three types of transitions that occur in the Territory's ECD MDS: transition from EHS to HS; transition from Part C to Part B programs and services; and transition from HS to Kindergarten. VIDE also provides special support for the transition of special needs children from Kindergarten to the first grade.
- Transitioning from EHS to HS includes a session with EHS parents and key staff from HS and EHS, as well as a half-day site visit of EHS children to a HS center which allows the children to "experience" HS in advance. It also involves the establishment of registration sites at different HS centers to facilitate the registration process for families.
- Transitioning of B-3 children from Part C to Part B programs and services begins when children are 2 1/2 years old and is spearheaded by VIDOH Part C staff who brings together parents as well as key personnel from the VIDE and VIDHS. Part C to Part B transition support activities are articulated in a 2011 MOA that specifies roles and responsibilities of agency personnel as well as supports that should be in place for children and their families.
- Transition from HS to Kindergarten include the opportunity for parents to enroll their children in summer "transition" programs that begin to prepare children for the transition

from HS to Kindergarten. VIDHS and VIDE also collaborate on the administration of the LAP-3 to HS children the spring prior to fall enrollment in Kindergarten.

- Notwithstanding transition supports currently in place, results of a Transition Survey reveal that gaps exist with respect to transition supports and that transition policies and supports need to be improved so as to improve outcomes for B-5 children who must transition through the Territory's ECE MDS.

Early Childhood Care and Education Facilities

- Almost three years after the passage of Hurricanes Irma and Maria, at least four Head Start centers remain closed as a result of hurricane damage, and several childcare facilities permanently closed their doors.
- GIS mapping reveals that there are certain geographic locations across the Territory that can be considered childcare deserts where there are no licensed childcare facilities, notably on St. Thomas on the western end of the island; on St. John, in the Coral Bay area; and on St. Croix on the northwestern and eastern areas.
- Although there are a larger number of facilities in the St. Thomas-St. John district, the capacity, in terms of enrollment, is higher in the St. Croix district due to terrain, space limitations, and costs associated with real estate in the St. Thomas-St. John district.
- The existence of waiting lists – as documented in this Needs Assessment, reflect the need for additional facilities or expanded capacity of existing facilities to accommodate B-5 children in need of services.

Early Childhood Care and Education Funding and Resource Use

- Public funding for the Territory's ECE MDS is provided primarily through the Federal Government, and specifically through the Department of Health and Human Services (DHHS), the Department of Education (ED), and the U.S. Department of Agriculture (USDA).
- DHHS supports HS, EHS, OCCRS, TANF, and MAP. Funding for HS, OCCRS, TANF, and MAP/CHIP flow through VIDHS and supports the Head Start program, childcare subsidies for qualified families, cash benefits for qualifying single-parent headed households, and public insurance eligible B-5 children and families.
- The USDA funds flow through VIDHS (SNAP), VIDOH (WIC), and VIDE (school breakfast and lunch programs). WIC supports access to nutritious meals for eligible pregnant women, infants, and toddlers and through established MOAs with HS and EHS, provides meals for children in these programs. SNAP supports access to nutritious meals for eligible children and families and VIDE provides access to nutritious breakfast and lunches to Kindergarten children enrolled in public, private, and parochial schools across the Territory who participate in the School Lunch Program.
- Currently, there is no blending of funds in the Territory's ECE MDS.

Summary and Discussion

This Needs Assessment provides comprehensive documentation of the Territory's ECE MDS. The document describes the vulnerable and underserved children in the Territory, as well as information on those receiving services and numbers on waiting lists for services. The document also speaks to gaps in data, not only to support collaboration, but also to optimally engage parents and provide a basis for parental choice within the framework of the current ECE MDS. Attention is given to the quality and availability of programs and supports for children B-5, with particular attention dedicated to programs and supports for children with special needs and children who are dual language learners (DLLs).

Further, the Needs Assessment identifies indicators of progress in the Territory's current ECE MDS and acknowledges the ongoing work needed to fully implement the Territory's QRIS, VIS2Q. The information on interagency collaboration and the evidence regarding system integration provide opportunities to strengthen the Territory's ECE MDS. This is particularly true with respect to the need to embrace the noted gap areas as opportunities to improve the Territory's ECE MDS by strategically addressing each of the gap areas and working towards improving and expanding communications across the entire ECE MDS. There is a significant opportunity to bring parents, private childcare center owners/operators and other providers to the table and ensure that policies are clearly articulated and disseminated in support of a high-quality ECE MDS so that all stakeholders support and understand the value of their voices and the need for their unique contributions.

Implications for Strategic Planning

The approach and governance structure of the development process of the Needs Assessment presented significant opportunities to identify gaps in data, research, and implementation of the USVI ECE MDS. The information presented here is critical to the development of a USVI ECE strategic plan that will focus on the Territory's use of human, physical and financial resources, policies, and time on the most impactful approach for the development of an ECE mixed-delivery system designed with the capacity to meet the needs of children from birth to age five, their families, and the community.

The USVI ECE Needs Assessment used a participatory approach to identify and review data and information regarding governance infrastructure, stakeholder relationships, outputs of programs and services, and capacity of providers involved in the current USVI ECE MDS. The advances that have been made and the challenges that exist illuminate a number of opportunities for an improved and more effective ECE MDS in the Territory. Key gaps are identified and threats associated with addressing these gaps during the strategic planning process are presented.

The information and data presented in the USVI ECE Needs Assessment provide a very detailed picture of the conditions and issues associated with the USVI ECE MDS. The information and data also offer strong indicators for the strategic plan and the goals that will acknowledge the potential threats to effective early child care and education and embrace the opportunities to significantly increase the number of children birth to age five, in the USVI, who thrive and become life-long learners.

NEXT STEPS

One of the critical actions that will be undertaken is the dissemination of the Needs Assessment. This dissemination will take multiple forms. First, the State Entity will host a number of sessions to present the Needs Assessment to key stakeholder groups – funders, policy makers, childcare facility owners and operators, caregivers, parents, advocates, and the research community.

Another major step will be the utilization of information presented in this Needs Assessment for the development of the Territory's new ECE MDS Strategic Plan as the U.S. Virgin Islands continues its journey on *The Road to Success: Developing an Early Childcare and Education Mixed Delivery System for the B-5 Population in the USVI*. Using the findings of the Needs Assessment, with a particular focus on the gaps identified, the Territory's ECE MDS Strategic Plan will provide the roadmap for moving the Territory towards having thriving children that reach their academic potential.

As next steps are addressed, policymakers will be engaged to obtain commitments to support, through policy and funding, the full implementation of the Territory's ECE MDS Strategic Plan, which will integrate elements of the outputs in support of parental knowledge, choice, and engagement, as well as identified ECE best practices. The Territory will continue moving forward on the *Road to Success* and will assess its success in doing so by implementing the PPEP and regularly updating stakeholders on progress being made in optimizing outcomes for the B-5 population in the U.S. Virgin Islands. Further, the Needs Assessment will serve as catalyst for collective change that leads the Territory's development of sustainable, high quality ECE outcomes for our B-5 population, with special supports for the most vulnerable in our B-5 population.

STATE/TERRITORY NEEDS ASSESSMENT CROSSWALK WITH PDG B-5 NEEDS ASSESSMENT REQUIREMENTS

Needs Assessment Domain	Corresponding Page Numbers
Definitions: Quality Early Childhood Care and Education (ECCE), ECCE Availability, Vulnerable or Underserved Children, Children in Rural Areas, ECCE System as a Whole	28-29
Focal Populations for the Grant: *Vulnerable or underserved children in your state/territory, and children who live in rural areas in your state/territory*	24-27
Quality and Availability: *Current quality and availability of ECCE, including availability for vulnerable or underserved children and children in rural areas*	45-73
Children Being Served and Awaiting Service: *Data available and/or plan for identifying the unduplicated number of children being served in existing programs and unduplicated number of children awaiting services in existing programs*	30-38
Gaps in data on Quality and Availability of programming and supports for children and families	137-138; 143
Gaps in data or research to support collaboration between programs/services and maximize parental choice	142-143
Measurable Indicators of Progress that Align with the State/Territory's Vision and Desired Outcomes for the Project	74-86
Issues Involving Early Childhood Care and Education Facilities	95-100
Barriers to the Funding and Provision of High-Quality Early Childhood Care and Education Services and Supports and Opportunities for more Efficient Use of Resources	101-104
Transition Supports and Gaps	87-94
System Integration and Interagency Collaboration	39-44

Stakeholder Input	Corresponding Page Numbers
Parents/family members or guardians	60-66; 88; 127-134
Child care providers from different settings *(e.g., center-based, Head Start, home-based)*	54-58;121-127
Child care providers from different parts of the state including rural areas and areas with diverse populations	105-114
Other early childhood service providers	118-121
State/Local Early Childhood Advisory Council(s) or other collaborative governance entity	89-90;114-118
Key partner agencies	5-6; 39-44 118-119

CHAPTER I: INTRODUCTION

I.1. BACKGROUND

The Preschool Development Grant Birth through Five (herein after, PDG B-5), was awarded as a one-year, federally funded project, *Road to Success: Developing an early childcare and education mixed delivery system for the B-5 population in the USVI,* under the direction of the University of the Virgin Islands' Caribbean Exploratory Research Center (UVI CERC), the designated State Entity. The PDG B-5 project, funded by the Administration for Children and Families Office of Childcare, through Award No. **90TP0023**, sought to develop a comprehensive strategic plan for a mixed-delivery system as a critical step towards strengthening and improving early childhood care and education (herein after, ECE) in the U.S. Virgin Islands (USVI). The four focus areas are:

(1) Improving the quality of care.

(2) Promoting collaboration and partnerships among persons and entities that provide early childhood care and education services.

(3) Providing high quality early childhood care and education options for low-income and disadvantaged families.

(4) Ensuring that parents and/or guardians have the requisite information and opportunity to make informed choices about ECE programs and providers in the USVI.

As a first step to developing the strategic plan, UVI CERC, as the State Entity, spearheaded the completion of a comprehensive Needs Assessment of the current B-5 ECE mixed delivery system in the USVI, the results of which are presented in this report. The Needs Assessment will inform the development of the USVI's PDG B-5 Strategic Plan as the roadmap for developing and sustaining a high quality, mixed delivery B-5 ECE system in the Territory. This Needs Assessment, then, is foundational to all subsequent work for the project and key to supporting funding requests for implementation of the USVI PDG B-5 strategic plan. The extant literature on ECE programs and services acknowledge the need for data (Jordan, King, Banghart, & Nugent, 2018) to guide policymakers and providers in delivering optimal care for children receiving these services. Importantly, integrated data systems at the state level are good tools for improving programs and services connected to the needs (health, education, medical insurance, social services) of B-5 children and families.

With the backdrop of two recent Category 5 hurricanes that significantly disrupted many systems in the USVI, particularly health, education, human services and housing systems (Michael, Valmond, Ragster, Brown, & Callwood, 2019), the PDG B-5 funding affords the Territory a unique opportunity to bring together stakeholders from key agencies and programs that provide care and educational services to the B-5 population. In coming together, stakeholders can work collaboratively to optimize human, fiscal, and other resources to develop a high quality ECE mixed-delivery B-5 system for the most vulnerable children in the USVI.

The long-term benefits of quality ECE programs for vulnerable or at-risk children have been well established in the literature (Hillemeier, Morgan, Farkas, & Maczuga, 2013; Rossin-Slater, 2015; Sabol & Hoyt, 2017). Some research shows linkages between early childhood education and health equity (Hahn, et al., 2016; Palmer, Ismond, Rodriquez, & Kaufman, 2019) and points to early care and education as social determinants that have implications for health disparities and health outcomes (Cohen & Syme, 2013; Palmer, et al., 2019;). For example, findings of a study by Chaufan, Yeh, & Sigal (2015) support the introduction of healthy eating habits in early childhood education settings as a means of contributing to reductions in childhood obesity and the burden of related diseases in later years. Further, Scott, Looby, Hipp, & Frost (2017) posit that childcare is uniquely positioned to employ an equity approach to reducing health disparities and promoting health equity. To accomplish reductions in disparities and promotion of equity, there is a need for more focused research, which is often best accomplished through community-based participatory research (CBPR) methods. Scott, et al. (2017) also note the importance of researchers deliberately applying an equity and health equity framework to childcare research.

A recent publication by the National Academies of Science, Engineering, and Medicine (2019) noted that early childhood care and education could be a lever to promote health equity and that attention to equity in policies, practices and programs is important for improving childhood outcomes. Research by Christopher, et al. (2015) emphasizes that the links with quality of curricula used in preschool programs are important to the high-quality instructional interactions needed to support school readiness of B-5 children from backgrounds of poverty.

Additionally, the critical role that early childhood care and education play in children's academic success has also been established in the literature. For example, the question of whether there is a difference in the performance of students who attended preschool and those who did not was studied by Gayden-Hence (2016). Study participants were recruited from six high schools in six different Mississippi school districts. Findings based on results of standardized testing of seniors and review of their third-grade test scores, revealed that private preschool attendees had the highest mean scale scores of all preschool groups in third grade MCT Reading. Those seniors who did not attend preschool scored next highest, with public preschool and Head Start being the lowest. However, students having attended public school preschool had a statistically significant predictor of student positive performance on the ACT.

Additionally, drawing from an extensive review of the literature, Brown (2002) makes a compelling case supporting the link between early learning and care and school readiness. Sources are cited that speak to how structured early learning and safe, caring, and nurturing environments boosts a child's chance for future success in school and life. Examples are provided that relate to brain development, readiness to learn, and success in school. It is noted that children who enter kindergarten behind their peers are unlikely to ever catch up. This observation supports the value for closing the achievement gap by implementing high quality early learning programs as a key strategy and an investment that pays off.

Other researchers (Morrissey & Vinopal, 2018) investigated associations between Head Start and other types of center-based ECE participation and found that neighborhood disadvantage, as measured by the poverty rate, is associated with poorer achievement outcomes in kindergarten. However, based on their finding that Head Start children in moderately-high poverty neighborhoods scored one-tenth of a standard deviation higher than those participating in Head Start in low poverty neighborhoods, it is suggested that Head Start may serve a particularly important role in disadvantaged communities. Morrissey & Vinopal (2018) note that, based on previous documentation in the literature, the structure, content, and quality of ECE settings are highly variable. There continues to be disparities in access to high-quality settings across low- and high-income families, and across low- and high-income communities.

Cavadel & Frye (2017) posit that while policy stakeholders often concentrate on the outcomes that children should achieve, the identification of the skills necessary to produce those outcomes should be viewed as the greatest opportunity for intervention. Using a short-term longitudinal design with a sample of 120 Head Start and kindergarten children the researchers investigated school readiness and prediction of academic skills and concluded that *Theory of Mind* and the combination of several socio-cognitive variables successfully predicted concurrent relations with academic outcomes. One such socio-cognitive variable is children's understanding of teaching. Preschoolers in the study were able to identify standard teaching situations, and the kindergarten and first grade children were also able to identify teaching in the context of play. Children's understanding of teaching predicted changes in literacy scores over time.

Few studies have focused on ethnically diverse, multi-language learning, and children living in poverty who are at risk for low academic success. Manfra, Squires, Dinehart, Bleiker, Hartman & Winsler (2017) explored the associations between preschool skills and Grade 3 achievement. They explained that academic achievement in Grade 3 has become a significant point of interest for many stakeholders and policy makers interested in the successful long-term learning of students through high school and beyond. Researchers have determined that Grade 3 has been identified as an important transitional grade because it tends to be the last grade in which instruction focuses purposively on learning to read as an isolated academic skill as teachers in subsequent grade levels begin requiring students to read texts to learn scholastic material (Manfra et al, 2017). According to Manfra et al, (2017) the findings, from a four-year longitudinal study, indicate that early counting/pre-mathematics skills and writing/copying fine motor skills are among the strongest and most consistent predictors of both mathematics and reading performance in Grade 3 across both measurements for low-income, ethnically diverse children. They tracked 2,447 children in their last year of preschool prior to entering kindergarten who were assessed on cognitive, language, and motor school readiness skills.

The Abecedarian project, a comprehensive early education program for young children at risk for developmental delays and school failure, showed statistically significant program effects on achievement beyond grade three. The project reported higher cognitive test scores in adulthood for the ECE participants, who received higher scores on reading and

mathematics tests, had more years of education, and were more likely to attend university than the control group (Smith, 2014). Another study suggested that programs should help school and parents increase their engagement in math and language skills. Identifying the mechanisms by which mathematics and literacy are related and how these connections may differ over time is a critical next step in understanding the development and interactions of early academic skills (Purpura, Logan, Hassinger-Das, & Napoli, 2017; McCormick, Weissman, Weiland, Hsueh, Sachs & Snow. 2020).

The early childhood research summarized here anchors the Needs Assessment in terms of the critical nature of the work and the need to focus on key elements of the Territory's ECE MDS. Areas such as parental engagement, quality of programs and services, access to healthcare, sensitivity to cultural differences, as well as the need to ensure that programs take into account the effects of poverty on children need to be considered within the context of addressing gaps in the Territory's ECE MDS.

I.2. The State Advisory Council

Recognizing the importance of bringing stakeholders together to address the ECE mixed-delivery system in the USVI, and as a means of meeting one of the requirements of the PDG B-5 funding, the State Advisory Council (herein after, SAC) was established. The USVI's SAC comprises a wide range of individuals who represent the diversity of the stakeholders that are part of the Territory's ECE mixed-delivery system. SAC members, invited to serve by the Governor of the U.S. Virgin Islands, are charged with assisting with the development of an exemplary B-5 Mixed Delivery Early Childhood Care and Education System through collaboration and stakeholder engagement. SAC members have worked and will continue to work collaboratively with the project team to:

(1) Promote the importance and benefits of strategic partnerships with public and private programs to ensure the health and well-being of the pre-school age children in the territory.

(2) Build on existing partnerships and develop new partnerships that ensure access to health, social and educational services for children ages B-5.

(3) Continue to build a strong network of collaborative partnerships that support health and well-being of children ages B-5 in the Territory.

During the development of the Needs Assessment, in addition to participation in regular quarterly meetings, SAC members participated in two special meetings to provide feedback

relative to preliminary findings, assist with filling various data gaps, and provide guidance and support with respect to the scheduling of primary data collection opportunities. [*See Appendix I.A. for a listing of SAC members*.]

I.3. Conceptualization

The approach taken to complete the Territory's ECE mixed-delivery system Needs Assessment included the establishment of the Core Team, the Project Committee (PROCOM), and the Partner Agencies and Organizations (PAOS). Additionally, SAC members were actively engaged through the creation of workgroups, which, in addition to SAC members, comprised PAOS representatives, and other individuals with expertise in the area of early childhood. The formation of workgroups aligned with the guidelines provided by the Administration for Children and Families (ACF) for the development of the Needs Assessment. Each workgroup had a charge, along with related objectives to guide the work in support of the development of the Needs Assessment. [*See Appendix I.B. for a listing of the workgroups established, along with workgroup membership, charges, and objectives.] [See Appendix II. for a listing of the Core Team, the PROCOM members, and the PAOS members.*] In addition to serving on workgroups, SAC members also supported the identification of administrative and secondary data. The process of developing the Needs Assessment also included sharing preliminary information with SAC members during regularly scheduled meetings. Additionally, SAC members in key agencies supported primary data collection efforts by facilitating data collection with key personnel and program participants.

I.4. Specific Aims

The U.S. Virgin Islands ECE mixed-delivery system's Needs Assessment aims to:

1. Describe the B-5 population in the USVI based on key demographic variables.
2. Describe the current ECE programs and services available for B-5 children and their families in the USVI (number of programs; enrollment capacity; staffing, to include credentials of staff; cost of services, etc.)
3. Describe the curriculum and assessment systems in place in the ECE programs in the USVI.
4. Describe gaps and barriers in ECE programs and services in the Territory.
5. Describe the quality of ECE programs and services currently available to B-5 children and their families.
6. Document perceptions of parents/guardians whose children attend ECE programs in the Territory.

7. Document funding available for existing ECE programs and services in the Territory.

I.5. EXPECTED OUTCOMES

This Needs Assessment provides information that describes and/or documents the:

1. B-5 population in the USVI based on key demographic variables.
2. Current ECE programs and services available for B-5 children and their families in the USVI *(number of programs; enrollment capacity; staffing, to include credentials of staff; cost of services, etc.)*.
3. Curriculum and assessment systems in place in the ECE programs in the USVI.
4. Gaps and barriers in ECE programs and services in the Territory.
5. Quality of ECE programs and services available to B-5 children and their families.
6. Perceptions of parents/guardians whose children attend USVI ECE programs.
7. Funding available for existing ECE programs and services in the USVI.

CHAPTER II: METHODS

II.1. STUDY DESIGN/APPROACH

To carry out the study, the research team used a concurrent, mixed-methods design (Creswell, 2009). Primary data collection included the collection of quantitative (survey) and qualitative (key informant interviews, focus group discussions, and town hall meetings) data. Secondary data were also a critical component of data collection and included the collection of administrative data, programmatic reports from relevant agencies, and census-related data. As required for the IRB application, proposed survey instruments and protocols for qualitative data collection were included as elements of the IRB application (Phases I and II).

II.2. STUDY PARTICIPANTS

Sampling

Study participants were adults from Head Start/Early Head Start (HS/EHS), day care centers, preschool sites, private and parochial schools, governmental agencies, community-based organizations/non-governmental organizations (CBOs/NGOs), faith-based organizations, community centers within the public housing community across the Territory, and other entities serving B-5 children and their families in the St. Croix and St. Thomas-St. John Districts. The team used convenience sampling, inviting all teachers, parents, and stakeholders at sites visited for data collection to participate in the study. Data collection within housing communities was limited to those having children ages birth through five years old and the sites selected based on data provided by the Virgin Islands Housing Authority (VIHA), using probability proportionate to size (PPS) sampling. For selected communities, the team received the support of VIHA staff to distribute a recruitment flyer to residents with children in the B-5 age group; thus, all residents who met this criterion had an opportunity to complete a parent survey.

The team recruited both males and females for participation and made every effort to ensure that participants represented the range of racial and ethnic groups receiving services through the USVI's ECE mixed-delivery system. Additionally, teachers, assistant teachers and other staff involved in the HS/EHS programs, as well as caregivers in preschool and day care center programs participated in the study.

II.3. Instrumentation and Data Collection

The project team used several survey instruments in completing the Needs Assessment. First, study participants completed a brief demographic survey. Additionally, since a primary focus of the Needs Assessment was to understand childcare services available in the Territory, parents and guardians of children B-5 across the Territory completed the *Quality of Care Questionnaire*, an instrument about childcare from a parent's point of view. Additionally, teachers and caregivers of children B-5 completed a survey that focused, in part, on language and literacy development. Other stakeholders completed either a general Stakeholder survey, an Early Childhood Transition questionnaire, or an Early Childhood Inclusion questionnaire.

As with previous studies conducted by the research team (Michael, et. al, 2019; Michael, et.al, 2016; Michael & Valmond, 2016), qualitative data were collected to augment quantitative data collection. Key Informant interviews were conducted with key personnel from partner agencies – agency heads and persons with responsibility for data related to children in the birth through five age-range. Members of key stakeholder groups participated in Focus Group discussions and members of the community were invited to participate in Town Hall meetings.

Instrumentation

Instruments for Quantitative Data Collection

The instruments were selected after researching the current PDG B-5 literature, since several states/jurisdictions are further along in their work related to ECE mixed-delivery systems than is the USVI. With the exception of the Teacher/Care giver survey, and the brief demographic survey, all other instruments used are in the public domain and states and territories engaged in PDG B-5 work are encouraged to use the instruments, most of which were developed with funding received from the Administration for Children and Families (ACF) within the Department of Health and Human Services. To address the specific aims of the Needs Assessment, the team used the following instruments:

1) *Brief demographic questionnaire*: This instrument captures demographic information about study participants.
2) *Quality of Care survey* (from a parent's point of view): This instrument captures parents' experiences with childcare. The questionnaire begins with some general questions and then goes into several categories of questions represented by 11

sub-scales; a stand-alone questionnaire about affordability; and three open-ended questions (not used in the Needs Assessment work).

3) *Teacher/Care giver survey:* This instrument focuses on teacher/care giver knowledge of language and literacy development for children B-5.
4) *Stakeholder survey*: This instrument covers different aspects of the ECE system within the Territory, to include questions related to collaboration and system building; positive early learning experiences; strong families; and health.
5) *State Early Childhood Inclusion*: This instrument is a self-assessment related to the inclusion of children with special needs into ECE programs in the USVI; and,
6) *Self-Assessment for an Early Childhood Transition Infrastructure*: This instrument focuses on the transition processes in place within the ECE mixed-delivery system in the Territory.

Since most instruments used are in the public domain, permission was needed only from the author of the teacher/care giver questionnaire.

Instruments for Qualitative Data Collection

For qualitative data collection, *Key Informant (KI) interview protocols* and *Focus Group discussion protocols* included structured open-ended questions tailored to the specific stakeholders or stakeholder groups. The questions were developed in part based on the specific aims of the proposed study, as well as on the preliminary analysis of quantitative data to ensure that the qualitative data would add value to the quantitative data collected as well as clarify administrative/secondary data obtained by the research team. *[See Appendix III for IRB approval letter; annotated quantitative instruments; and all qualitative protocols.]*

Documents for Secondary Data Review

The team used the most recently published Virgin Islands Community Survey (2015) (UVI ECC) to examine socio-demographic variables related to the target population. Additionally, the research team requested administrative reports and planning documents from programs such as HS/EHS, Women, Infants and Children (WIC), Medicaid and CHIP, Maternal and Child Health (MCH), the Infants and Toddlers Program, and other programs that serve children birth through five years old in the US Virgin Islands. The team also retrieved Executive branch budgets and budget hearing testimony to capture information related to ECE programs and services available in the Territory.

Data Collection

Data collection was completed using two approaches. Throughout the data collection period, all stakeholders, Head Start (HS) and Early Head Start (EHS) teachers and assistant teachers and approximately one-third of HS parents and 100% of EHS parents who

participated in the study completed paper surveys. Daycare center and preschool teachers, assistant teachers, and parents completed surveys on a tablet using the innovative methodology of Audio Computer-Assisted Self-Interview Software (ACASI). CERC successfully used the ACASI technology in an Intimate Partner Violence (IPV) prevalence study conducted in the USVI and Baltimore, MD (in collaboration with Johns Hopkins University) (Stockman, et. al, 2013) as well as in Haiti, following the 2010 earthquake (Sloand, et al, 2015). More recently, the research team successfully used the ACASI technology for the community Needs Assessment that looked at health, education, human services, and housing needs of vulnerable children and families in the USVI, post hurricanes Irma and Maria (Michael, et. al, 2019).

For paper surveys, some teachers took as long as 90 minutes for completion, with the average completion time around 60 minutes. The average time was shorter for teachers who completed the survey on a tablet. Parents needed the least amount of time to complete paper surveys, for an average completion time of 30 minutes, and 20 minutes using the tablet.

Informed Consent

Members of the research team secured participants' informed consent prior to commencement of data collection. Because of the nature of the study and the participants, the Informed Consent Forms were developed using language and vocabulary that have been used in studies which included persons with no high school diploma. The University of the Virgin Islands' Institutional Review Board (UVI IRB) approved the quantitative instruments and qualitative protocols used for primary data collection [IRB No. 1428205].

Study Sample

Tables 1.1 and 1.2 provide a summary of stakeholder groups and the number that participated in various data collection activities across St. Croix, St. John, and St. Thomas. Parents who participated included those with children enrolled in Head Start, Early Head Start, Granny Preschool, and private day care centers and preschools. Teachers included HS/EHS teachers, private day care center and preschool teachers, as well as VIDE Granny Preschool and Kindergarten teachers. The group, other stakeholders, represent a range of persons including policy makers, day care center owners, HS/EHS middle managers, other ECE providers, and the general public.

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Table 1.1

Stakeholders Groups that Participated in Data Collection for the Needs Assessment

Stakeholder Group	St. Croix	St. John	St. Thomas	Territory
All Stakeholders	**278**	**35**	**242**	**556**
Parents	83	7	69	***159***
Caregivers/Teachers	102	14	94	***210***
Other stakeholders	93	14	80	***187***

Table 1.2

Data Collection Mechanisms Utilized in the Collection of Data for the Needs Assessment

Data Collection Mechanism	St. Croix	St. John	St. Thomas	Territory
All Data Collection Mechanisms	**278**	**35**	**242**	**556**
Quantitative Data Collection	*250*	*25*	*219*	***494***
Parent survey	83	7	69	**159**
Caregiver/Teacher survey	102	14	94	**210**
Other surveys (general stakeholder; inclusion; transition)	65	4	56	**125**
Qualitative Data Collection	*28*	*10*	*24*	***62***
Town Hall meetings	9	9	10	**28**
Focus group discussions	11	1	10	**22**
Key informant interviews	8	-	4	**12**

II.4. Data Analysis

Quantitative data were analyzed using SPSS 26. Descriptive statistics describe study participants and summarize the information garnered from the survey instruments. Reliability statistics were generated for each scale and appropriate scale scores for both the parent and teacher surveys. Quantitative analyses are presented within the context of the seven specific aims of the Needs Assessment. Qualitative data analysis was used to identify themes and inform contextual dimensions of the Territory's ECE mixed-delivery system in the Territory (Cope, 2010; Elliott, 2018; O'Connor & Gibson, 2003). The themes that emerged serve to triangulate and augment quantitative data (both primary and secondary) gathered to address the specific aims of the Needs Assessment project. Similarly, secondary data review and data abstraction were completed so as to address aspects of the study's specific aims and help ensure that the findings of the Needs Assessment are comprehensive in their representation of the current status of the ECE mixed-delivery system in the US Virgin Islands.

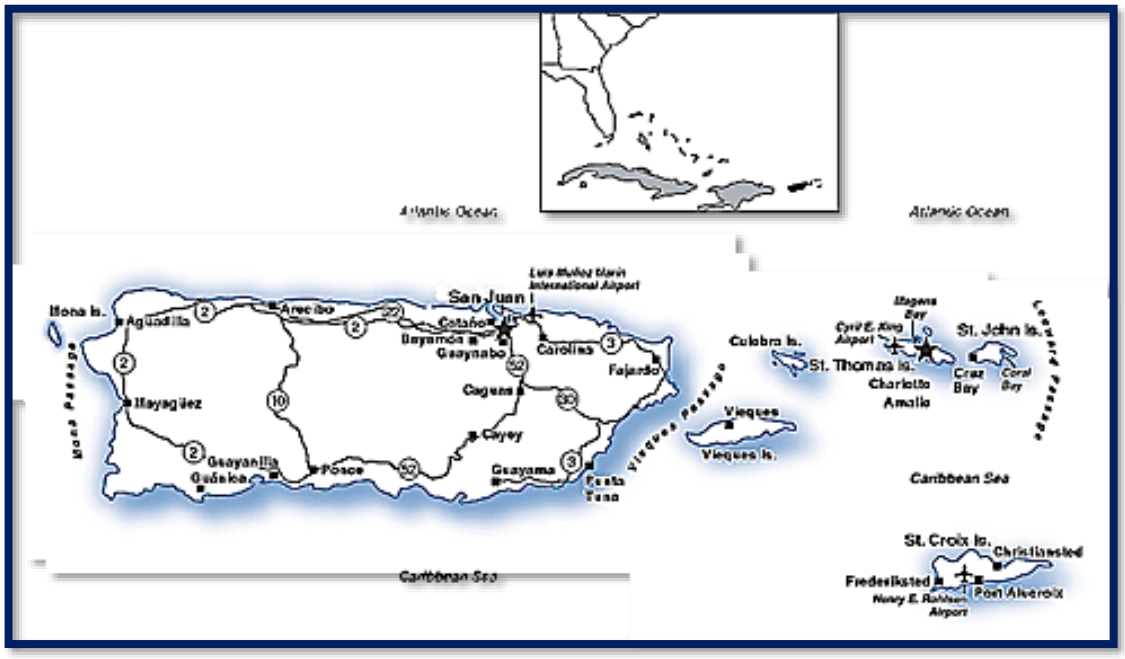
CHAPTER III: FINDINGS

III. 1. THE USVI CONTEXT

The Virgin Islands of the United States (USVI) began the journey of being an unincorporated territory of the United States in 1917 when ownership was transferred from Denmark. The group of four small islands and 50 even smaller islets and cays are 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 the US Mainland (Figure 1). The population of 100,768 (2015 VICS) lives on 133 square miles mostly on St. Croix (84 sq. miles), St. Thomas (32 sq. miles) and St. John (20 sq. miles) (Figure 2).

Figure 1. **The Caribbean Archipelago**

Figure 2. **Puerto Rico and the US Virgin Islands – The US Caribbean**

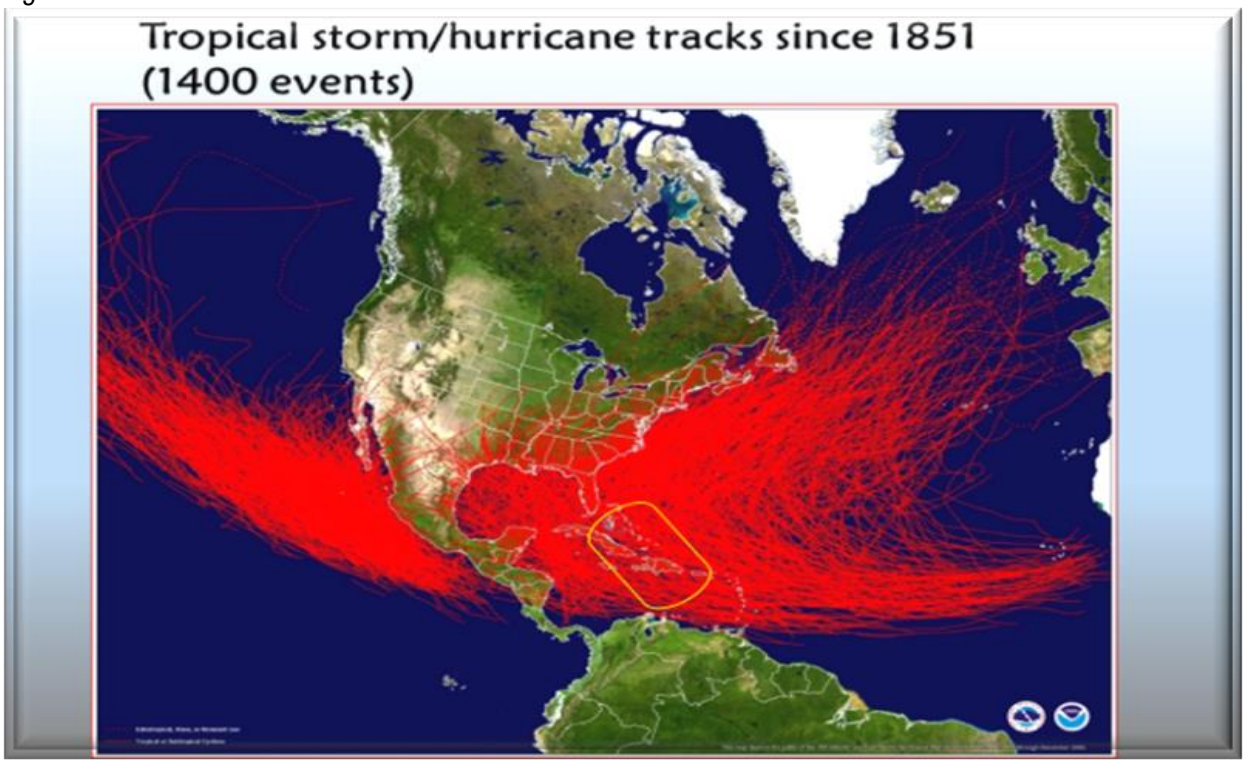


The communities of the USVI, like those on small islands across the planet, must find mechanisms and strategies to manage challenges to development and growth associated with limited size, fragile ecosystems, limited natural and institutional resources, uncertainty due to externally controlled transportation (for goods and service) and financial markets, and geographic isolation. The separation of the islands by miles of ocean creates the need to duplicate services while addressing the distinctions of the individual island communities. The cost of duplicated government infrastructure, especially in the areas of education, public safety, health, and public works, creates financial and management challenges that impact meeting the basics of life for the most vulnerable in the community.

A significant aspect of the conditions that affect implementation of sustainable development in the USVI is the occurrence of natural hazards like hurricanes, tsunami, drought and flooding, which are exacerbated by the various manifestations of climate change on the land, people and oceans. The USVI is a part of the “hurricane alley” in the Atlantic, and the probability of storms intensified by the earth’s warming must be factored into programs and services to prepare for the inevitable disruptions that can occur annually (Figure 3). Currently, the Territory is in the third year of recovery from the destruction and disruption caused by Hurricanes Irma and Maria in September 2017. Within this context, and with the current realities of mitigating the impact of the COVID-19 pandemic caused by the novel

Coronavirus, focusing on strengthening early childhood care and education as a key aspect of sustainable development for the USVI will pose a range of challenges for both policymakers and service providers as they seek to ensure that the most vulnerable children and families of these children have access to quality early care and education.

Figure 3. **Storm/hurricane tracks across the Caribbean**

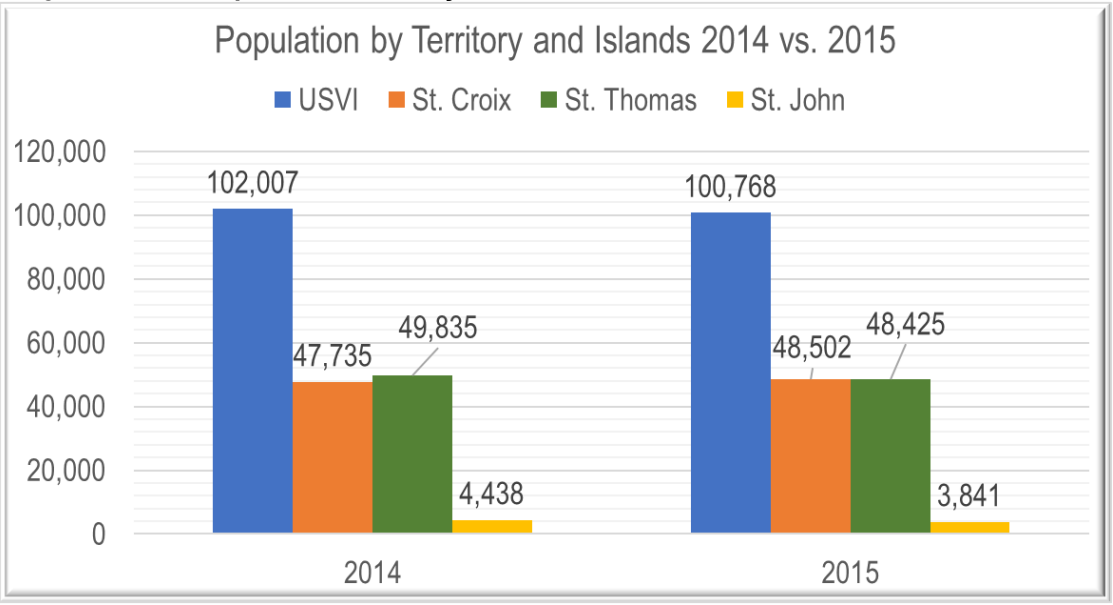


The USVI was focused on various aspects of community development within the context of its physical, social, and economic attributes and conditions before the major disruptions of the hurricanes in September 2017, including decreases and changes in the population and economic weakness. Moving from emergency relief to recovery efforts emphasized deficits in basic needs in the community such as secure housing, access to sufficient nutritious food, affordability of medicine, and adequate care systems for children and the elderly (Michael, et al., 2019). The 2017 hurricanes invoked such extreme experiences and outcomes that currently, conditions, and outcomes are measured against pre and/or post hurricane levels. These factors are important and relevant to the development of an effective USVI mixed-delivery system for early childhood care and education programs.

The U.S. Virgin Islands Population

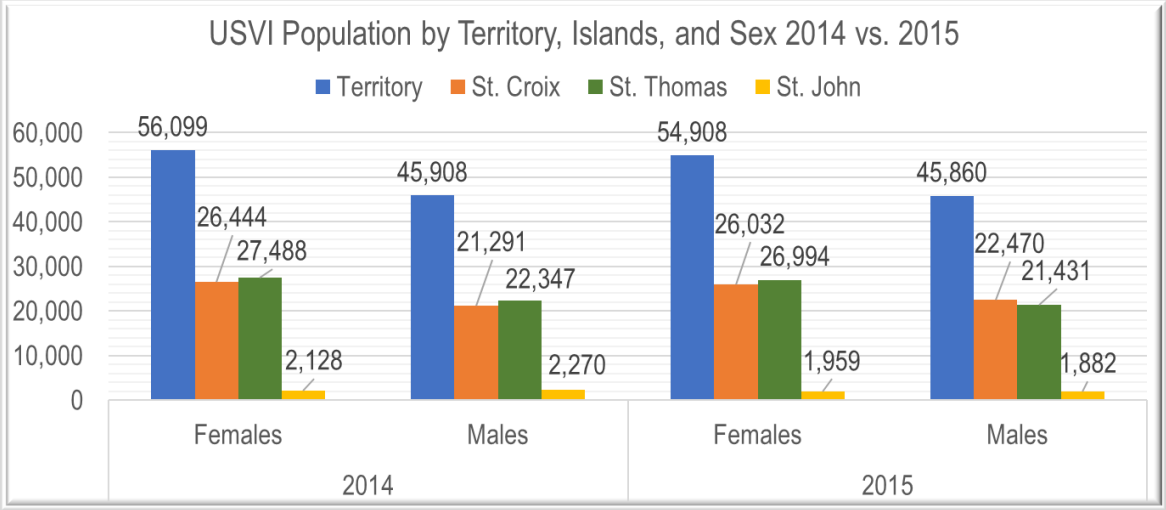
The 2015 Virgin Islands Community Survey noted a continuing decline of the population to 100,768 (2015) compared to 102,007 in 2014 (Figure 4), and 106,405 in 2010. Yet, it is worth noting that the population decline for the Territory is just over 1%, with a slight increase in the population for the St. Croix District (approximately 2%), while there was a 13.5% decline in the population of St. John and an approximately 3% decline in the population of St. Thomas.

Figure 4. **USVI Population: Territory and Islands – 2014 and 2015**



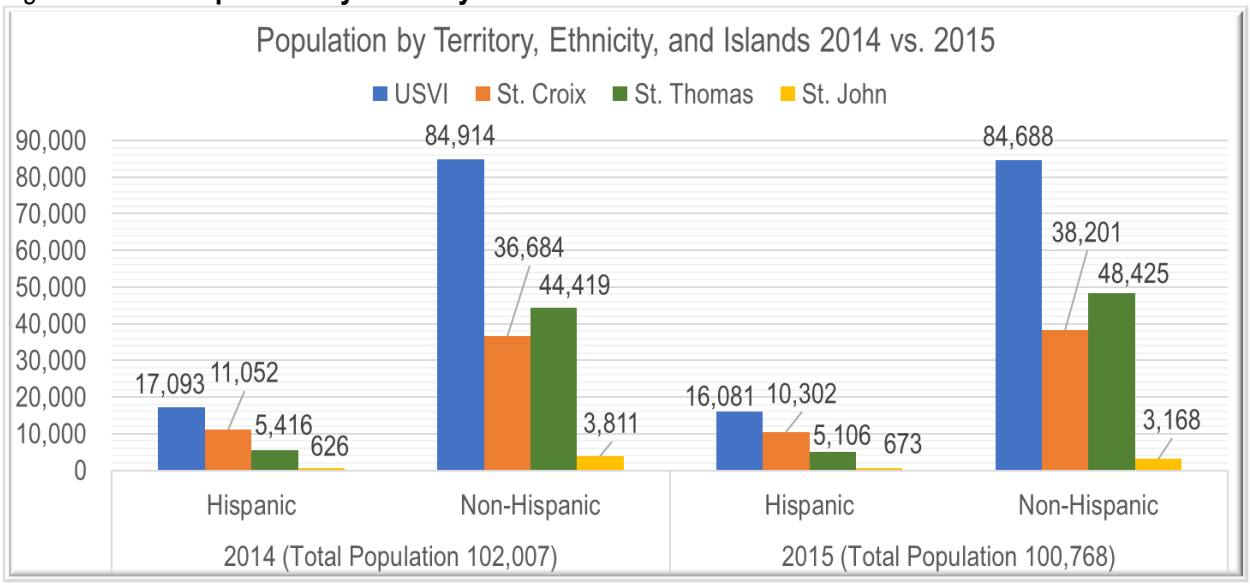
Non-census reports, including a 2016 report from the USVI Bureau of Economic Research, estimate the population to be 97,373, a 4.5% reduction in size from 2008. In 2017, the two Category 5 Hurricanes – Irma and Maria may have contributed to the continuation of this trend across the three main islands. Notable reductions in school enrollment from 13,194 in SY2016-2017 to 10,886 in SY2017-2018 (Michael, et al., 2019) serve as tangible indications of population changes. Data from the 2020 Census process are expected to answer questions regarding volatility and trends in the population following the 2017 hurricanes.

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



The evolving US Virgin Islands population continues to be over 50% female (Figure 5), multiethnic and multiracial despite environmental disruptions and the effects of a weak economy. The 2015 Virgin Islands Community Survey (2015 VICS) characterizes the population as 80% *Black* (African American or African Caribbean), 11.5% *White* and 8.5% *Other Races* with 16% of the population reporting Hispanic roots (Figure 6). On the island of St. Croix, as has been reported in the past, almost 1 in 4 individuals identify as having Hispanic roots, the highest percentage in the Territory. Sixty percent of the Hispanic population in the Territory is female.

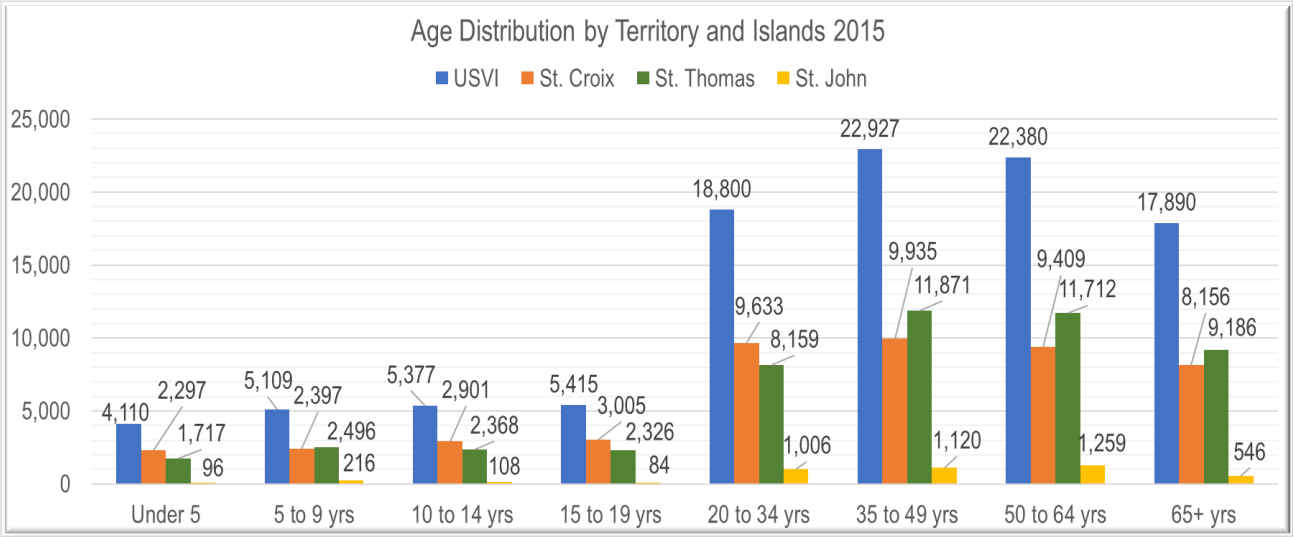
Figure 6. **USVI Population by Ethnicity and Islands**



In addition to the decline in the size of the population, the USVI continues to have an aging population with the median age of 44.5 reported in 2015 VICS. The data indicate that

62% of the population is older than 35 years of age while only 5% is less than 5 years old (Figure 7). Changes in USVI population trends, including recognition that 41% of the population is over 50 years of age, will require focused attention on emerging needs and changes in healthcare, education, the workforce, public housing, adaptation to climate impacts and disaster preparation.

Figure 7. **USVI Population by Age Distribution – 2015**



US Census reports documented the historic population decline experienced in the USVI when the population fell by two percent in the 2000 to 2010 period. Mather and Jarosz (2014) noted that this was the first time this change had been seen in the USVI's recorded history. During the same period of 2000 to 2010, the number of children in the USVI decreased by 21%, from 34,289 to 27, 2026. The 2015 VICS reports 21,327 children 19 and younger living in the Territory, enlarging the decline to 38% since 2000 (Figure 7).

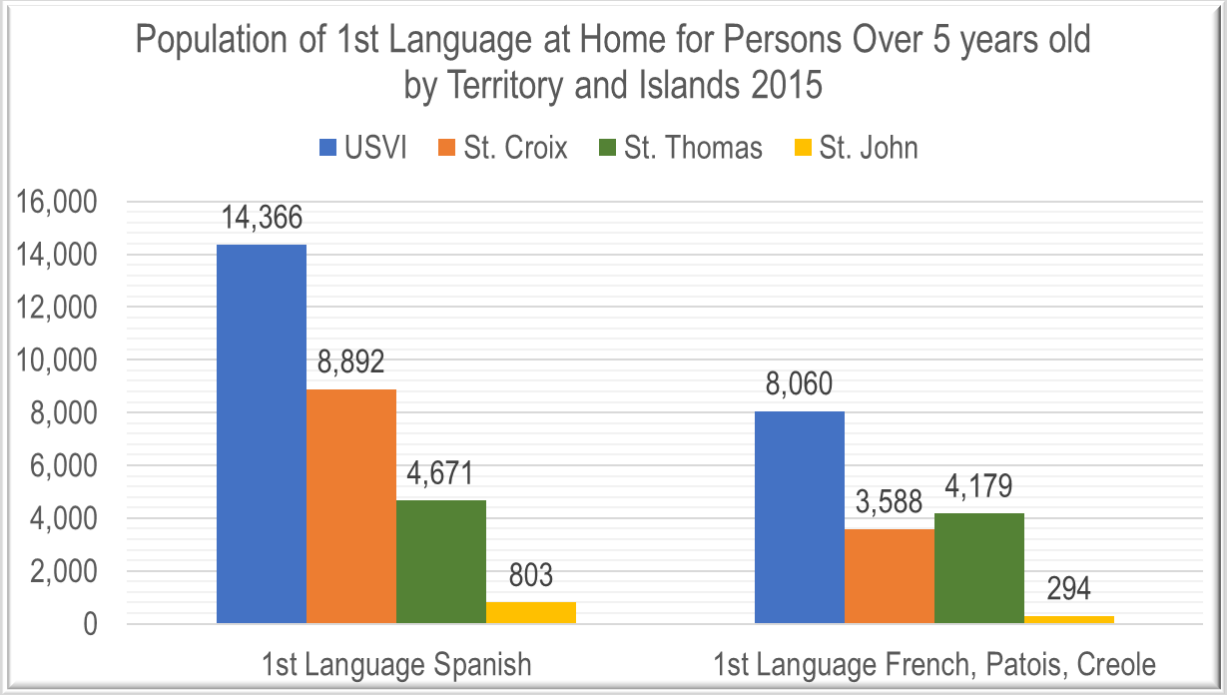
While the population of the USVI has declined over the past two decades, the increased diversity in the population is significant. The population of the USVI comprises various size groups of people from many places, especially the island-states and territories of the Caribbean and states of the US. Individuals from Canada, Europe, Central and South America, India, the Middle East, China and African countries are classified in the *Elsewhere* category in the 2014 and 2015 VICS. The 2015 VICS reports the largest group of residents born outside of the USVI come from the island-states of the Caribbean, with Dominica contributing 15% and the Dominican Republic adding 14% to this group. In the US Virgin Islands, English is the primary language spoken, but the reality is that on each of the three

main islands the cultural practices, foods, dialects, and other languages of the various groups in the population have been integrated into traditions and everyday activities of the Territory.

Languages Spoken at Home

Additionally, one in four households in the USVI may speak other languages besides English at home. The 2015 VICS reports Spanish and French Patois or Creole as the two most prevalent non-English languages spoken by individuals over 5 years old in the USVI (Figure 8). `Across the Territory, sixty percent of the second language speakers are conversing in Spanish that may reflect the dialects and vocabulary of Puerto Rico, the Dominican Republic, Cuba, or South American countries.

Figure 8. **First Language Spoken at Home – Territory and Islands – 2015**



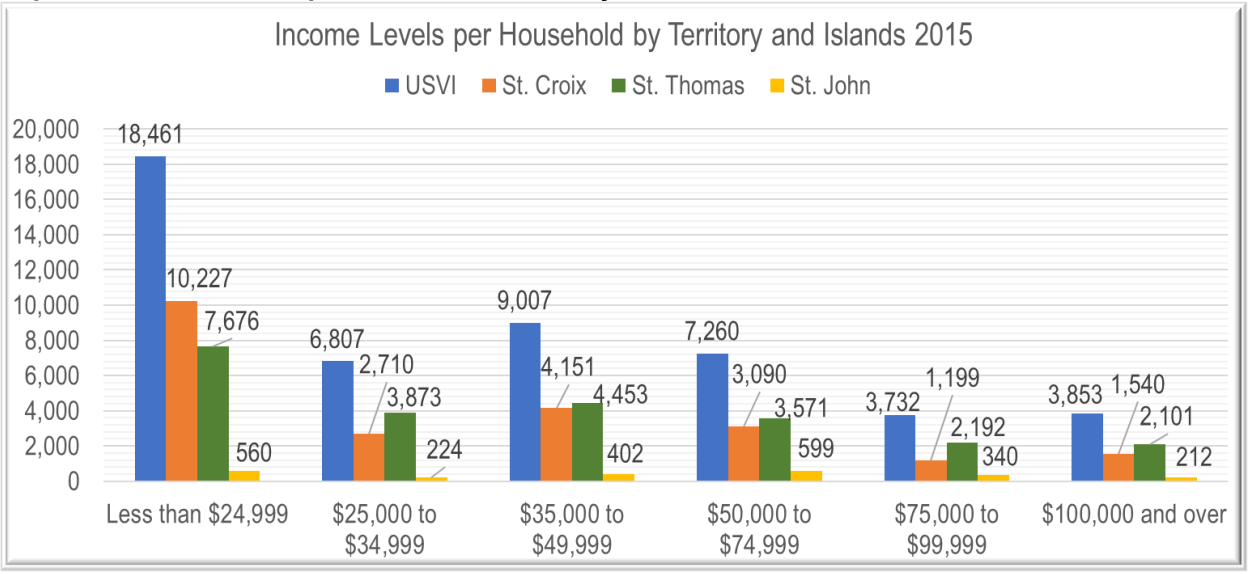
Income

The USVI populations must manage the challenges associated with the economic costs of being physically isolated from the US mainland and large markets by over a thousand miles of ocean, limited natural and institutional resources, and vulnerability to natural hazards like hurricanes and earthquakes. The devastation of property and the disruption of economic activities and lives by Hurricanes Irma and Maria in 2017 exacerbated the challenges facing the people and the Government of the USVI. Years of recovery from economic downturns and Category 5 hurricanes will occur under conditions where 20% (5,197) of the families in the

Territory are living below the Federal Poverty Line (2015 VICS) and 49.5% (2,594) of these families have single female householders. Figure 9 (2015 VICS), portraying the income levels in the Territory, shows that 22,356 households (49.8%) are earning at or below the median income level of $33,964, which would disqualify some households from receiving assistance even though they are not earning enough to fully address the costs of living with their income.

Employment and economic activities in the USVI that influence the standard of living and quality of life of birth to five-year old children and their families have been challenged and been in a weakened state since 2008 when the economy contracted due to the *Great Recession* and was further destabilized 2012 when the oil refinery on St. Croix closed (USVI Bureau of Economic Research, 2016). The Territory is currently still in recovery from two Category 5 Hurricanes in 2017 and is navigating the economic fallout from COVID-19, which essentially closed the Territory's economy for approximately four months, to date.

Figure 9. **Income Levels per Household: Territory and Islands – 2015**

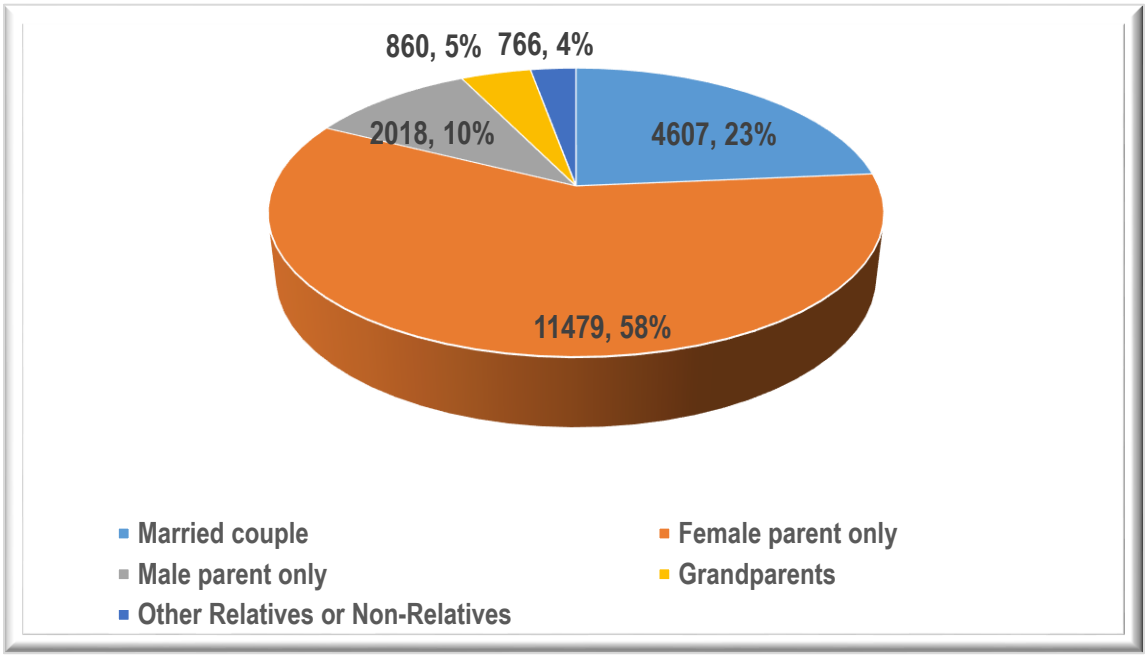


Household Composition

Families in the USVI share a special type of kinship that comes in different forms and focuses on support and decision-making critical to producing engaged, productive community members. The dominant family structure in the USVI is the single female as head of the household with at least one child. Figure 10 presents the USVI population by family composition based on 2015 VICS data. The data in Figure 10 highlight range of household arrangements with at least one child under age 18, and that approximately one in five (23%)

households are headed by couples, while 58% of households with children under 18 have single females as the head of the household. The data also point to the need for support services for the almost 70% of USVI families that have only one guardian and one source of income. Additionally, single females head 67% of the households with children under 6 years of age and 38% of these families have income levels that fall below the poverty line.

Figure 10. **USVI population by household relationships – 2015**



Education Attainment

Despite awareness of the value of education to a higher standard of living, the educational attainment levels of the population remaining in the USVI are not outstanding. The national rate of high school diploma achievement has been improving, with 90% of 2018 students receiving high school degrees compared to the decrease in Virgin Islands diplomas from 77% in 2014 to 70% in 2015 (2015 VICS). Although 70% of the population over 25 years is reported to have education credentials at high school or higher levels, 77% of individuals between 18 to 24 years have education credentials at least at the high school level (2015 VICS).

Figure 11. **Educational Attainment of USVI Population – 2015**

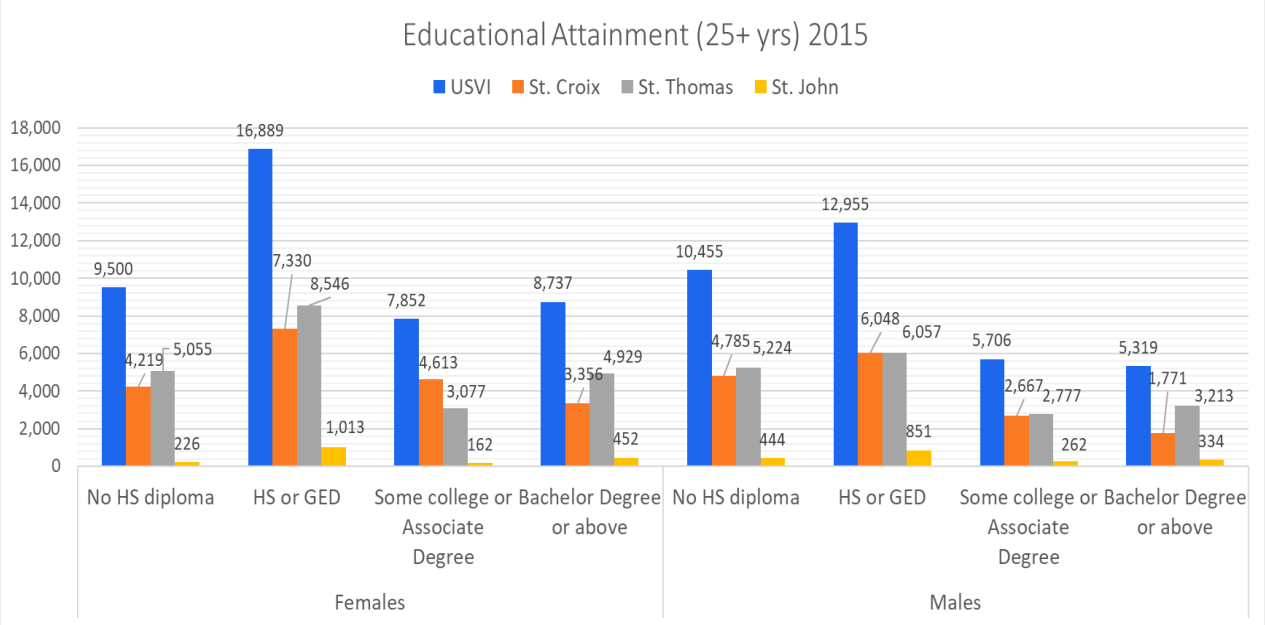


Figure 11 indicates that St. John has the highest level of educational attainment and that across the Territory females over 25 years have earned the most education credentials, with 18% having a bachelor's degree or above. The level of higher education credentials in the Territory is considerably lower than the 1 in 3 (33%) of higher education graduates at the national level (US Census 2016). Educational attainment in the USVI is influenced by the flow of students and credentialed adults out of (and into) the Territory for various reasons, including natural disaster disruptions, employment opportunities and economic downturns. Large-scale demographic or economic changes are likely to require the VI Government and the community to make decisions about education infrastructure and incentives for retaining qualified professionals to support community development goals.

Health Environment

Experiencing good health that allows an individual to be productive at work and enjoy life in general are part of the life goals of many Virgin Islands' residents. Accessibility and affordability to these amenities can pose challenges under conditions of poverty and small community size in isolated islands. In the USVI, access to healthcare services are addressed through Medicaid, Medicare, personal finances (uninsured) or third-party healthcare insurance. The 2015 VICS reported that 22% of the population did not have health insurance coverage. This decrease in the number of uninsured individuals from a high of 30% before 2014 is likely to be partially linked to the benefits received from the Affordable Care Act (ACA)

through the increase in the Medicaid cap. This increase in the Medicaid cap resulted in the availability of more funding to the USVI to support insurance coverage for eligible persons.

The health of the people of the Territory and the USVI healthcare system have been of concern to researchers at the University of the Virgin Islands Caribbean Exploratory Research Center (UVICERC), and agencies that monitor health disparities. Before the disruption of the hurricanes in 2017, the USVI population was known to have high incidences of cardiovascular diseases, hypertension, diabetes, cancer, and an underlying condition of obesity. More than 20% of the patients receiving services at the FQHCs in the Territory were treated for hypertension (Health Resources and Services Administration UDS Data Center, 2016). The Kaiser Foundation (2017) noted in its health report on the USVI for 2017 that 13% of the population was reported as having to manage living with diabetes, a higher level of prevalence than the 12% reported nationally. Additionally, the 2016 BRFSS revealed that 65.2% of the adult population were overweight or obese (Centers for Disease Control and Prevention).

School Enrollment

The Virgin Islands Department of Education (VIDE), under the leadership of the Commissioner of Education and a Superintendent of Schools for each of the two school districts – St. Croix and St. Thomas-St. John – delivers K-12 public education in 25 schools across the Territory. The K-12 enrollment in SY2018-2019 of 10,728 was accomplished with the reassignment of students from two elementary schools that had been closed due to hurricane damages and the use of modular units, as needed. Additionally, as reported by VIDE's Office of Research, Planning, and Evaluation (PRE), in 2018, 25 parochial and private schools provided K-12 education to approximately 3,000 children across the Territory.

VIDE collects and reports enrollment data for public, private, and parochial schools. Additionally, VIDE also has jurisdiction over homeschooling in the Territory, and requires that educational outcomes for homeschooled students be reported to VIDE. Public, parochial, and private schools in the USVI receive supplemental funds from the U.S. Department of Education. The funding is awarded to VIDE and disbursed to all schools on a formula basis anchored in enrollment levels. ECE options for children B-5 include publicly funded Early Head Start and Granny Preschools (St. Croix only) and Head Start Programs on St. Thomas and St. Croix; privately funded preschool programs and childcare centers on all three islands; and informal childcare arrangements with family, friends, and neighbors (FFNs).

III.2. The USVI B-5 Population

As reflected in the previous section, *The USVI Context*, the most recent, available data on the composition of the USVI population are reported in the 2015 VICS (Eastern Caribbean Center, 2018). In researching data on the USVI B-5 population, it became evident that population data for this age group is not readily available for individual ages. Thus, even using the 2015 VICS, the available numbers pose a challenge in that five-year old children are aggregated in the category "5 to 9 years". As such, the two tables that follow highlight key demographic information for the "B-5" population and reflect data for children B-4 only.

Table 2

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	-

As captured in Table 2, the Virgin Islands Community Survey (2015) reports 5,241 children (5%) being between birth and 4 years old, with 2,674 (51%) living on St. Croix. Of the 2,567 in the St. Thomas-St. John District, 2,516 (47%) reside on St. Thomas and 51 (2%) reside on St. John. These numbers reflect a decrease in the USVI population under five years old, when compared to the 2010 census (7,500 or 7% of the overall population). Of all children under five years of age, females account for approximately 44% (2,297). With respect to

ethnicity, Territory-wide, 762 (4.7%) of children under the age of five were identified as Hispanic, with the larger proportion of these children in the St. Croix District (611 or 5.9%).

Table 3 captures data reported in the 2015 VICS pertaining to early childhood education enrollment across the Territory for children ages 3 and 4. Generally, children begin kindergarten at age 5 and would then be categorized as being enrolled in elementary school rather than preprimary school. Of all persons three years and over enrolled in school, approximately 8% (1,708) were enrolled in preprimary school in 2015. Of these, just over three of every four children were enrolled in a public preprimary "school". Based on the ages under consideration, this would likely be the Head Start programs across the two districts. A larger proportion of children in the St. Croix District were enrolled in public preprimary schools than in the St. Thomas-St. John District (86% compared to 69%). Further, as captured in Table 3, territorially, just under two in five preprimary enrollees were female compared to one in three in the St. Thomas-St. John District.

Table 3

Preprimary School Enrollment by District and Race, U.S. Virgin Islands 2015

School Enrollment	Virgin Islands				St. Croix				St. Thomas and St. John			
	Total	Black	White	Other	Total	Black	White	Other	Total	Black	White	Other
Enrolled Persons – 3 years and over	**20,471**	17,476	1,258	1,736	**10,519**	8,535	490	1,493	**9,952**	8,941	768	243
Preprimary	**1,708** (8.3%)	1,532	69	108	**742** (7.1%)	634	-	108	**966** (9.7%)	2,435	110	22
Public Preprimary	**1,307** (77%)	1,159	40	108	**640** (86%)	532	-	108	**667** (69%)	23,769	3,976	1,131
Females	10,270	8,701	673	896	5,067	4,017	231	819	5,203	4,684	441	77
Preprimary	**624** (37%)	583	-	40	**319** (43%)	278	-	40	**305** (32%)	305	-	-
Public Preprimary	**418** (32%)	278	-	40	**254** (40%)	213	-	40	**164** (25%)	164	-	-

As a proxy for the number of five-year old children in the Territory in 2015, kindergarten enrollment data are provided in Table 4, since the 2015 VICS does not have data for five-year old children as a distinct age category. These data are limited to overall counts only, since VIDE did not have enrollment data available by race for all schools. As can be observed from

Table 4, 1,042, or approximately 71% of five-year old children in the Territory in 2015 attended public schools, with the enrollment relatively evenly divided by district – 51% in the St. Thomas-St. John District. Again, using kindergarten enrollment as a proxy for the number of five-year old children in the Territory in 2015 (based on the 2015 VICS), five-year old children would have represented approximately 7.2% of the school enrollment, a slightly lower percentage than pre-primary children (ages 3 and 4). The use of kindergarten enrollment acknowledges some degree of error, given that there are families that homeschool their children in the Territory and enrollment fluctuates across the school year, based on in and out migration. However, taken together, the 2015 VICS' numbers and the kindergarten school enrollment (5,241+1,464) suggest that, based on the last population estimates calculated for the USVI, children ages B-5 represented approximately 6.7% of the population in 2015.

Table 4

Kindergarten Enrollment by District, U.S. Virgin Islands SY 2014-2015

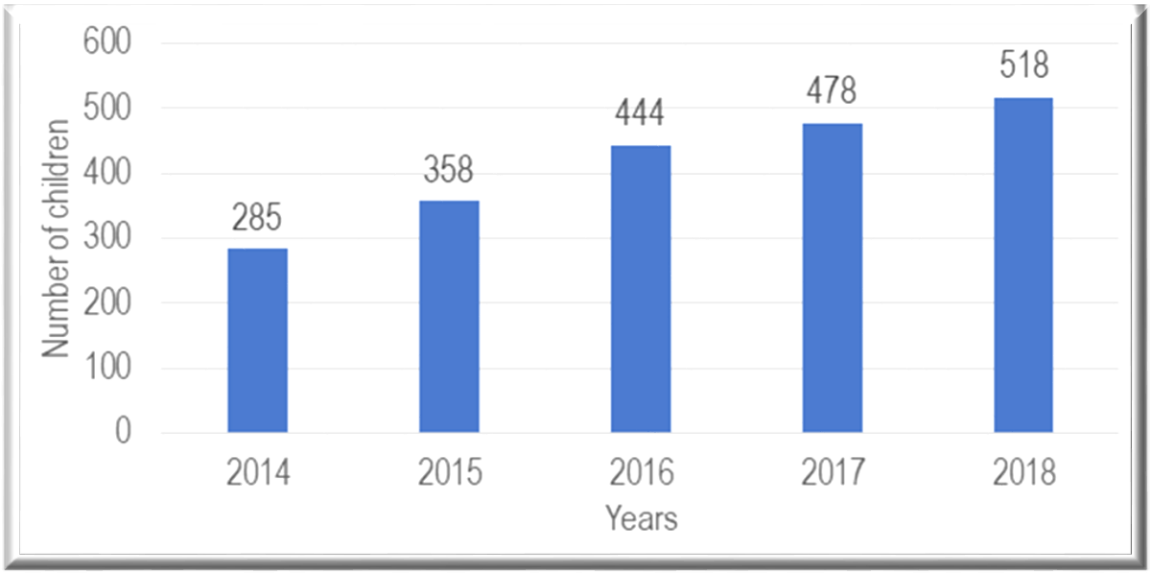
Kindergarten Enrollment	Territory	St. Croix District	St. Thomas-St. John District
All Schools	**1,464**	723	741
Public Schools	**1,042**	515	527
Private & Parochial Schools	**422**	208	214

Data from the 2015 VICS indicate that the majority (86%) of children under five years of age were born in the US Virgin Islands, and 7% had Caribbean countries listed as their birthplace. Sixty percent (60%) of the Caribbean born children are from the Dominican Republic and Haiti, which could be used as a proxy for the need for second-language services (i.e. ELL classes and possibly 504 plans). Further, the 2015 VICS identifies 25,964 families in the Territory with 17% (4,479) being families with related children under 6 years old. The 3,015 families with single-female headed households and children birth through five years of age make up 12% of the 25,964 families in the Territory. Twenty-six percent of the 5,197 families living below the poverty level in 2015 had children under 6 years old and 86% (1,142) of those families living below the poverty line with at least one child between birth and 5 years old, which were distributed approximately equally across St. Thomas and St. Croix, were single-female-headed households. Another indication of the vulnerability of this population is captured in data that show 13% of children birth to 5 years of age in the USVI as being

uninsured and 60% of the insured birth to 4-year old children access healthcare through Medicaid.

Data from the Virgin Islands Housing Authority (VIHA), the agency responsible for providing affordable housing to qualified persons in the Territory, point to an increasing number of children under 6 years of age living in public housing (Figure 12). The VI Housing Authority reported that in 2019, 879 children under six years old resided in public housing or living in private housing using vouchers to supplement rental costs, which is approximately 17% of children birth through five years of age.

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



Similar to the lack of aggregated data on key demographic variables for the birth to five-year old population, data on the health status and use of the public healthcare system for birth to 5-year old children is not aggregated and it is unclear how much of the data is unduplicated. The information on children birth to five years of age can be found in reports generated by the HS/EHS programs, the MCH & CSHCN Program, and the Infants and Toddlers Programs. Other data are captured in VIDOH Vital Statistics reports and in the reports submitted by the two USVI FQHCs to the UDS. The USVI birth through five-year-old population is a critical part of the future of the Territory and the indicators from limited data available provide strong signals to treat this group as underserved and vulnerable.

III.3. KEY TERMS AND DEFINITIONS

Process used to Identify Key Terms and Definitions

Guided by its charge and objectives, the *Definitions Workgroup* identified the most salient terms related to the Territory ECE mixed-delivery system for inclusion in the Needs Assessment. Using a collaborative approach, draft definitions were shared with the SAC for feedback and the definitions included have received the support of the SAC.

The terms and definitions included reflect the specificity, cultural sensitivity and common linguistic distinctions nationally and locally ascribed to what the Territory envisions comprises its ECE mixed-delivery system. Secondary sources used to inform the definitions included the Early Childhood Advisory Council (ECAC), Code of Federal Register, and various websites. Robust discussions occurred concerning the challenge in using specific definitions across and within government departments, whose eligibility requirements for services may differ in how recipients met low-income standards or qualified for waivers due to homelessness, placement in child protective care and foster care.

Discussions also played a major part in fulfilling the four objectives that guided the final approach. Those discussions led to consensus, for example, after researching and discussing the term *rural*, the Definitions Workgroup agreed to use the Census Bureau's definition of rural. It was determined that, for grant eligibility purposes, federal government funding opportunity announcements regularly designate the USVI as rural; however, the rural designation may vary by federal agency. For example, all locations in the USVI are eligible for Rural Health Grants. Definitions used by HRSA, OMB, the Federal Office of Rural Health Policy (FORHP) and the Department of Education were explored in the process of developing the USVI PDG B-5 definitions list. For other key definitions, research was conducted on the Territory's ECE mixed-delivery system, with special attention given to terminology specific to programs, database systems and practices currently in place. This process gathered information and then narrowed the choices to the definition best suited to understanding the contextual realities in the USVI.

Additionally, after reviewing the key terms and definitions for inclusion, SAC members recommended additional terms and definitions for inclusion in the Needs Assessment. These are included as *Appendix IV*.

Abbreviated Key Definitions

"Childcare Desert" - an area that either has no childcare providers or has so few that there are more than three children for every available slot.

"Displacement" - According to a 2006 Federal Emergency Management Agency (FEMA) document, displacement specifically means somebody who has been vetted and documented by federal officials as needing government-subsidized housing, expense money and other assistance because of a natural disaster.

"Early Childhood Development" - Early childhood spans from birth to age 8 years. This is a time of critical change and development as a child attains the physical and mental skills he/she will use for the rest of his/her life. The Center on the Developing Child at Harvard University compares brain development to the architecture of a house: building a strong foundation during this early childhood period helps ensure a solid structure in the future.

"Homelessness" - Section 725 of the McKinney-Vento Act, as amended by the ESSA, defines the following terms:

(a) Homeless children and youths means individuals who lack a fixed, regular, and adequate nighttime residence.

"Quality Early Childhood Care and Education": (A) a Head Start program or an Early Head Start program carried out under the Head Start Act (42 U.S.C. 9831 et seq.), including a migrant or seasonal Head Start program, an American Indian/Alaska Native Head Start program, or a Head Start program or an Early Head Start program that also receives State funding; (B) a State licensed or regulated childcare program; or (C) a program that— (i) serves children from birth through age six that addresses the children's cognitive (including language, early literacy, and early mathematics), social, emotional, and physical development; and (ii) is— (a) a State prekindergarten program; (b) a program authorized under section 619 or part C of the Individuals with Disabilities Education Act; or (c) a program operated by a local educational agency.

"Vulnerable or Underserved Children" - The Department of Health and Human Services (HHS) characterizes underserved, vulnerable, and special needs populations as communities that include members of minority populations or individuals who have experienced health disparities.

III.4. Early Care and Education Programs and Services: Who is being Served

The more that is known about who is receiving services and the existence of service gaps, the better policymakers in the USVI will be able to support full access to high-quality early care and education to all children in the Territory. By linking broad types of data together, decision makers can gain a more complete picture of the EC services children receive. However, the U.S. Virgin Islands, like some other jurisdictions, does not yet have a functional early childhood integrated data system (ECIDS) that can provide answers to questions concerning participation in various types of programs and services or offer unduplicated counts of children across all EC programs territory-wide.

There are a variety of reasons for the unavailability of unduplicated counts of the number of children receiving ECE services across the Territory. These reasons range from instances wherein the data available on the number of children being served in an existing program reflect only counts aligned with compliance reporting requirements that sometimes failed to delineate discrete age groups such as children birth through five. In other cases, some agencies utilize data management services provided by consultants in firms that are based outside the Territory and this sometimes results in limited direct access to program data and, or protracted timeframes for responses to requests for data.

From birth through kindergarten entry, children in the USVI are engaged in a variety of early care and education programs and services. Some of the secondary program data received from the agencies administering these programs lacked the specificity and comprehensiveness necessary for determining unduplicated counts of who is being served in USVI ECE programs. Explicitly, some data were provided in summary form that did not allow for separation of the target population – children birth through five years of age – which presented a challenge since the data were not sufficiently granular. This created limitations as to how the data could be represented in the Needs Assessment. Other data were incomplete and missing information for assessing trends in longitudinal data sets or there were gaps in the data for an entire district.

In the absence of a comprehensive integrated data system, that links child-, family-, and program-level data across ECE programs, it is challenging to access data from multiple services and supports in order to generate an accurate portrait of the needs and service gaps

for children 0-5 and their families. 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. Despite the importance of linking program data to identify potential gaps in services, information about who receives services are often compartmentalized in the departments of the respective service providers. Furthermore, the Territory is not represented in many Federal databases. In sum, having easy access to data, in particularly unduplicated counts, pertaining to the availability of quality childcare programs, types of mechanisms used to track quality and information about the number of children and families awaiting service is not a straightforward process. The data represented in this Needs Assessment reflect the isolated pockets of data that exist, which when analyzed, these data provide a glimpse of the services used by families and children in the Territory.

For example, data reported by the Women Infants and Children (WIC) program show a constant decline in the number of participants in that program. Figure 13 shows that there has been a 43% decrease in the average total of WIC participants between FY 2015 and FY 2018. The largest decline in the average children and average infants took place after hurricanes Irma and Maria in September 2017. The average total children and the average total infants reported declines 31% and 25% respectively, between FY 2017 and FY 2018.

Head Start and Early Head Start Enrollment

In the USVI, data on the total number of children enrolled in Head Start (HS) and Early Head Start (EHS) is also well-documented in Program Information Reports (PIR) for compliance purposes. The Territory is assigned 894 slots in Head Start centers to serve children in both the St. Thomas/St. John and the St. Croix districts. Early Head Start, which is administered by Lutheran Social Services of the Virgin Islands (LSSVI), only operates in the St. Croix district with two centers serving a total of 120 children and pregnant women.

Figure 13. **Participants in the Women, Infant and Children (WIC) Program: FY2014-2015 – FY2017-2018**

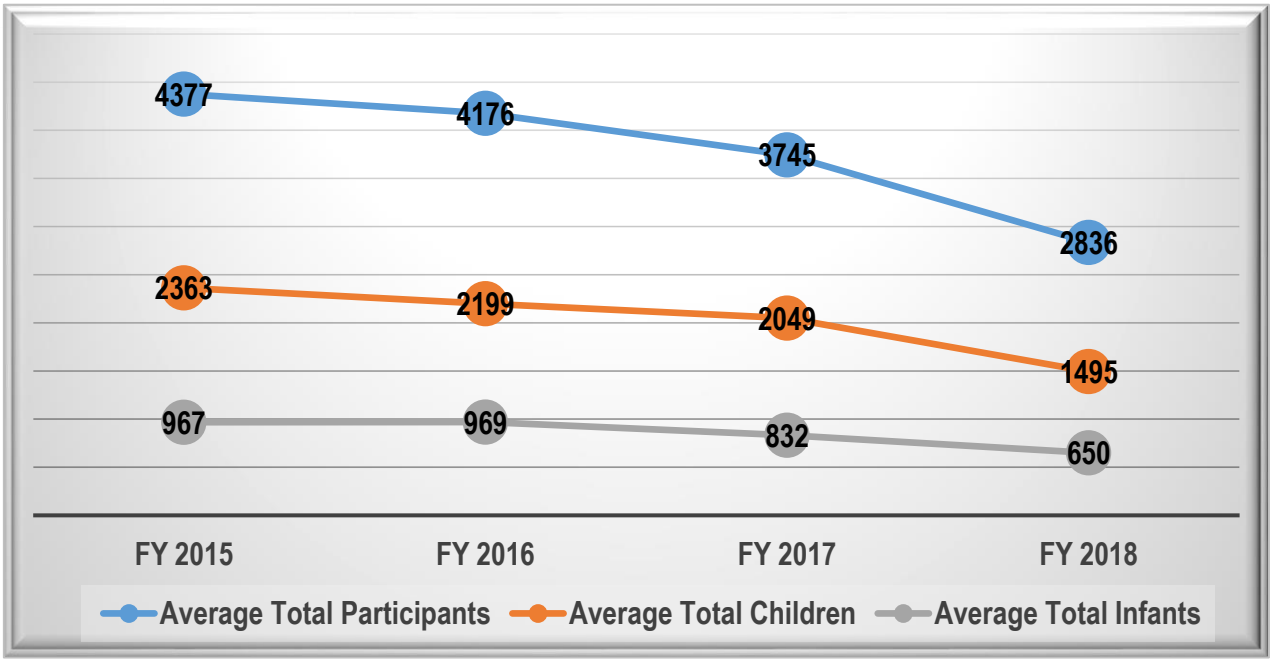
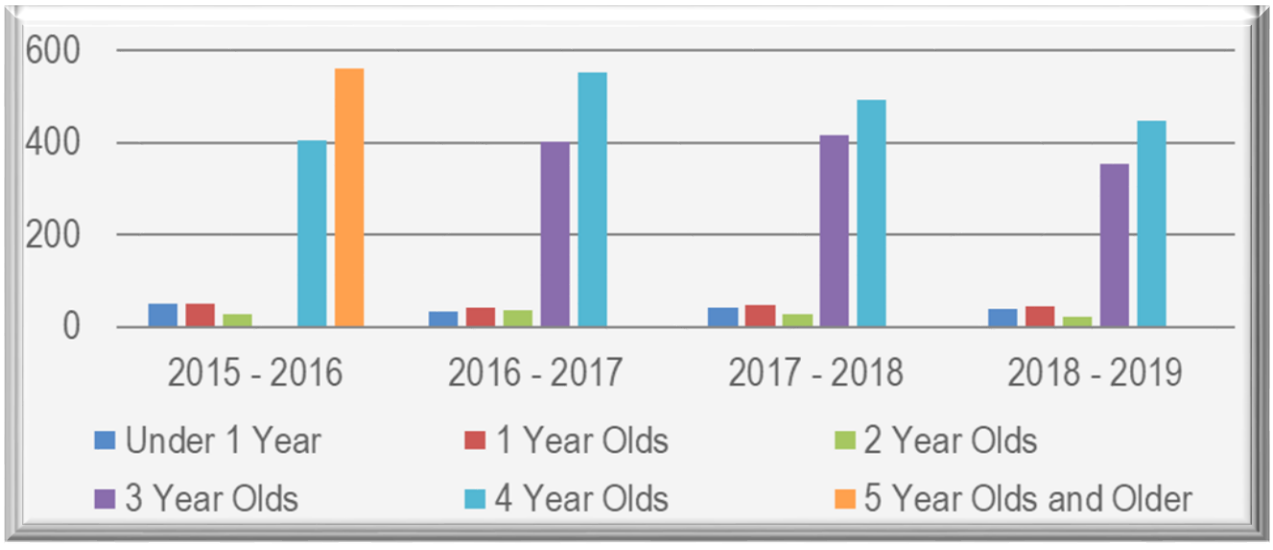


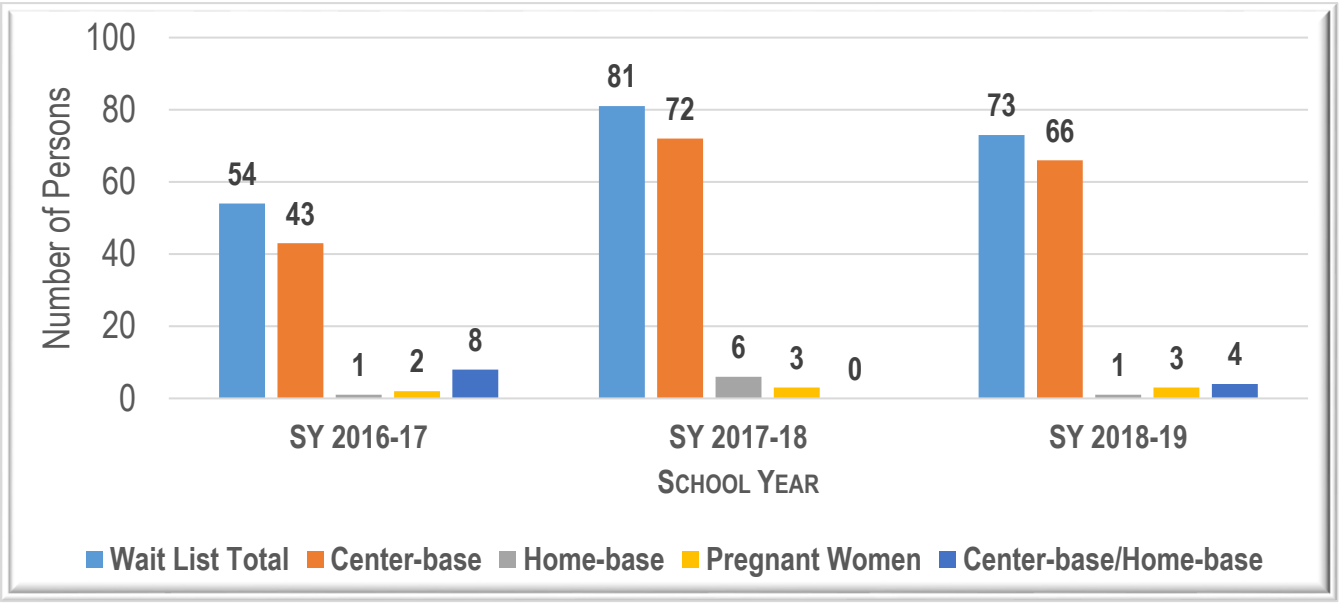
Figure 14, below, shows the age distribution of children in the HS/EHS system SY2015-2016 through SY2018-2019. The figure shows that there is a huge gap between the availability of service for 0-2-year-olds, who are served by EHS, and the number of 3 - 4 year-olds enrolled by HS. While there is a dearth of data about what happens to children before they attend HS at age 3, there is information about children on a waitlist awaiting HS enrollment in both districts (Figure 16) and awaiting EHS placement on St. Croix (Figures 15a and 15b).

Figure 14. **Children enrolled in Head Start and Early Head Start by Age: SY2015-2016 – SY2018-2019**



Data from the EHS program show the high demand for the services they provide. As noted before in this section, the EHS program is only offered in the St. Croix district and there are 120 slots available for children 0-2-year-old and pregnant women. Figure 15a shows that for two of the three years the number of persons awaiting service from EHS was more than one-half of the program's current capacity. EHS center-based service experiences the highest demand with between 80% to 90% of the total number on the list awaiting that type of service in the review period, SY 2016 – 2017 to SY 2018 – 2019 (Figure 15.1).

Figure 15.1. ***Early Head Start wait list by type of service category: SY2016-2017 to SY2018-2019***



LSSVI operates two EHS center-based programs, Concordia East and Concordia West, in the St. Croix district. Figure 15.2 shows that there is a greater demand for center-based service at Concordia East than Concordia West during the SY 2016-2017 to SY 2018-2019. The reasons for this difference is expanded upon in Section III.9, which focuses on ECE facilities.

Figure 15.2. **Early Head Start wait list by center: SY2016-2017 – SY2018-2019**

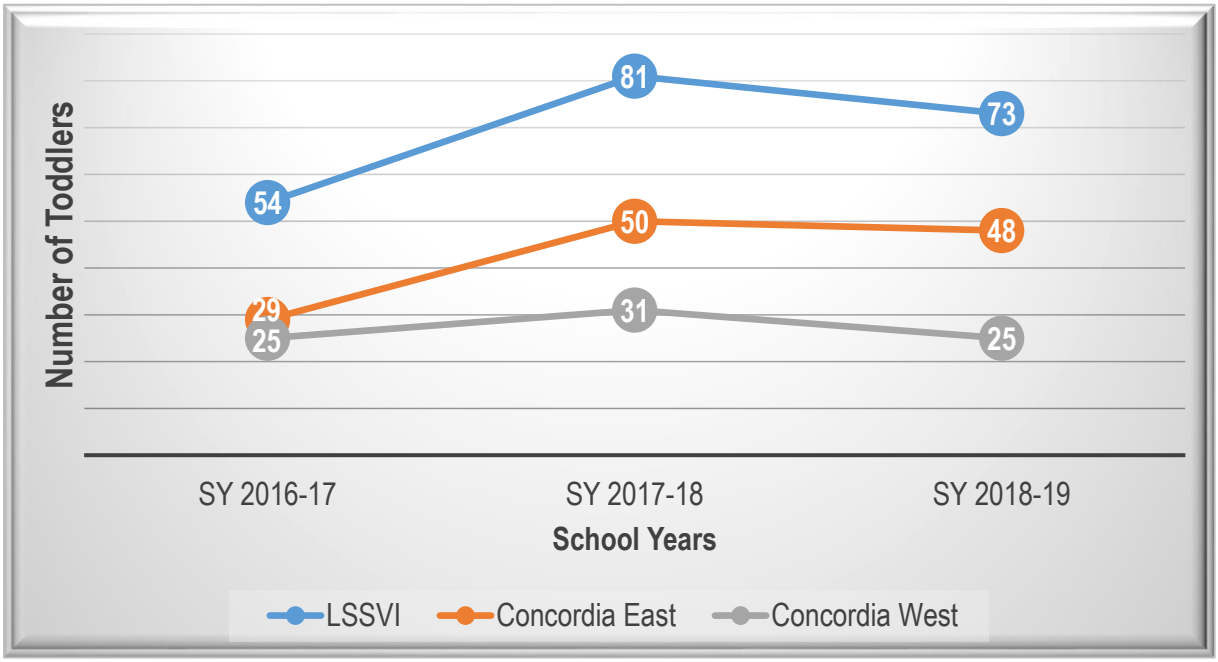
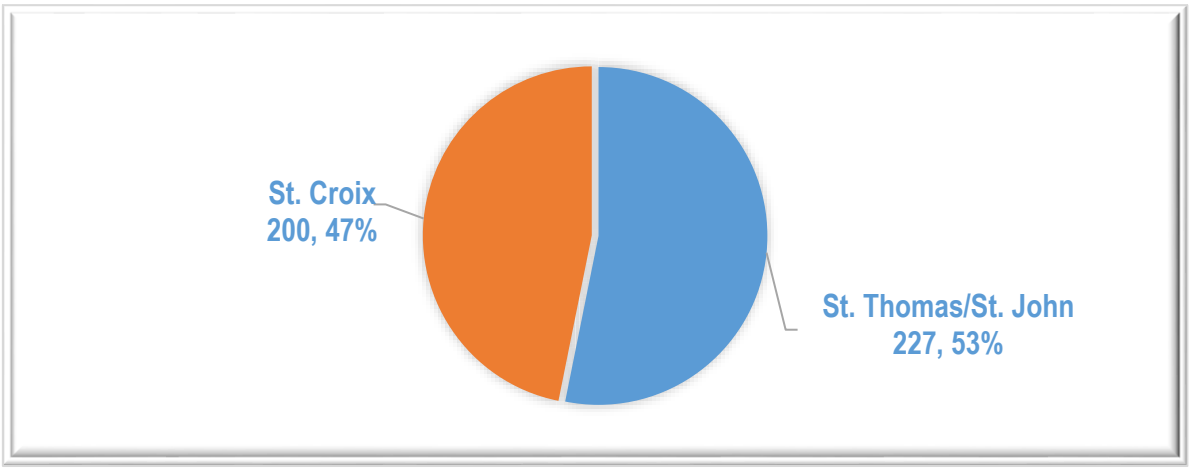


Figure 16 shows that there were 427 children on the waitlist for enrollment in HS programs, in the Territory, in school year 2018-2019. The waitlist reflects, in part, the continuous challenges facing the VIDHS since the hurricanes Irma and Maria forced the closure of some HS centers in the Territory.

Figure 16. **Children on the Head Start Waiting List by District: SY2018-2019**



The decision to capture and document data for waitlists vary by programs, as some programs offering services to families with children birth through five, capture waitlist data and others do not. Given this fact, the data received from an agency such as the Virgin Islands Housing Authority (VIHA) about children awaiting services in existing programs might not

reflect unduplicated counts. However, the team received waitlist data from two VIHA programs that provide services to families with children five years old and under.

Figure 17. **VIHA PHA Waiting List by District for children B-5: CY2013-2014 – CY2017-2018**

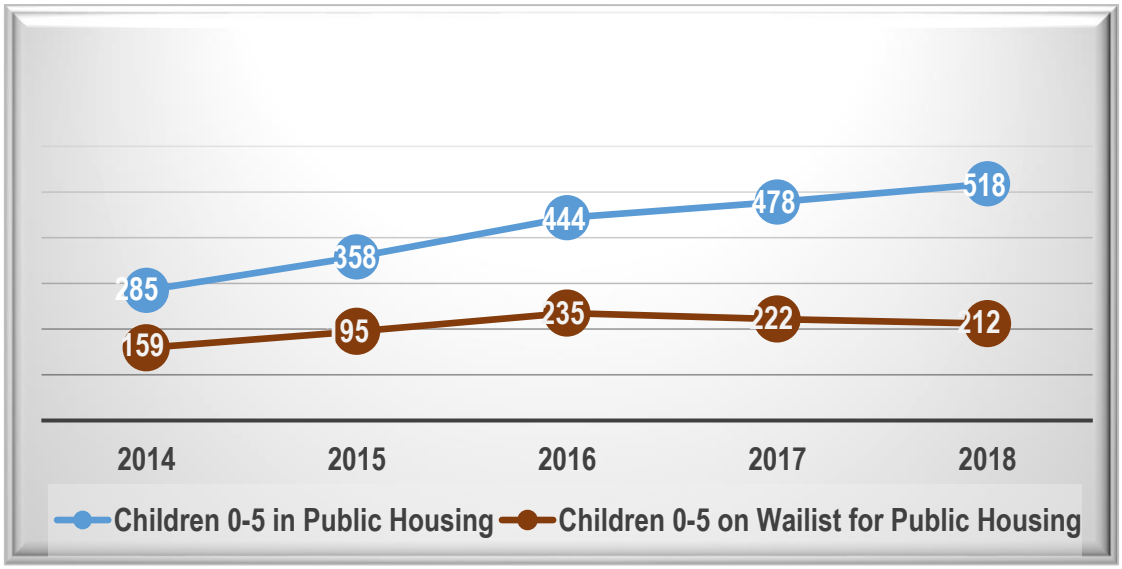
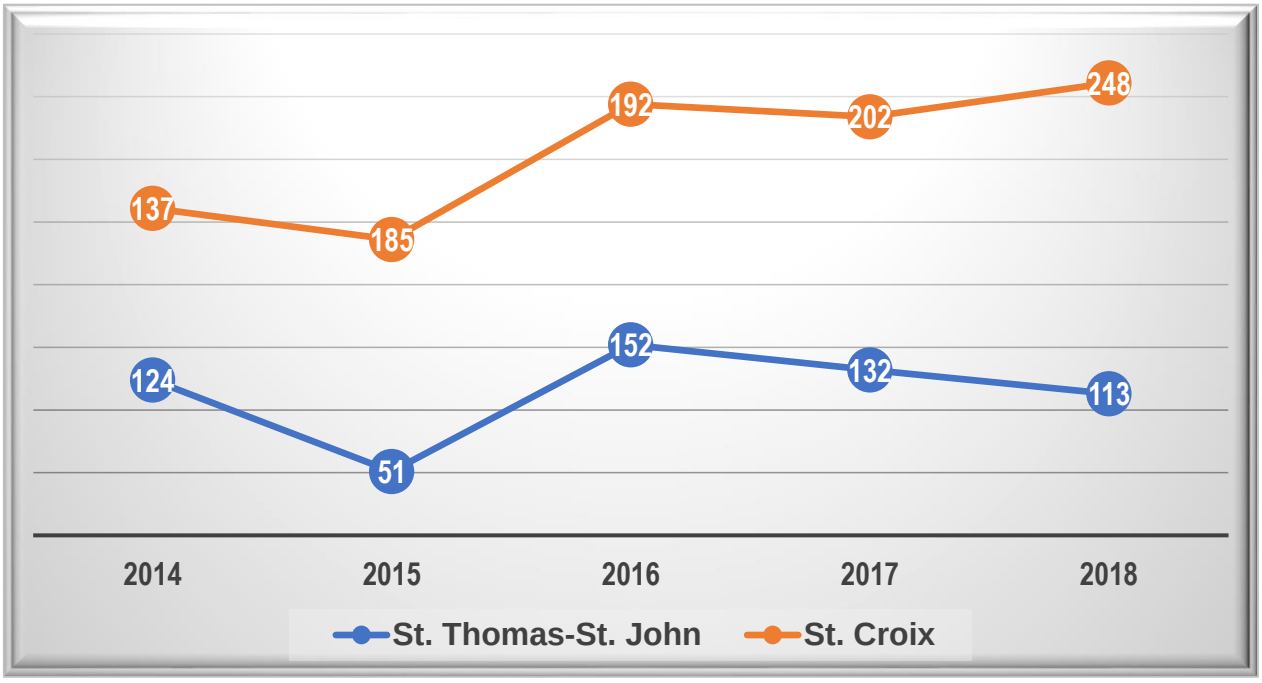


Figure 17 shows waitlist data received for public housing populations between CY 2013-2014 and CY 2017-2018. The VIHA reported an 82% increase in the number of children, five years old and under, living in public housing communities in the Territory during the five years. During the same period the number of children 0 -5 on waitlists awaiting services for public housing increased steadily from 159 in 2014 to 212 in 2018, a 33% increase. Of note is that families are free to apply for housing accommodations through both public housing opportunities as well as the Housing Choice Voucher Program (HCVP). Therefore, there is some overlap in the number of families with children B-5 awaiting housing through public housing (PH) (Figure 17) and the number of families with children B-5 awaiting housing through the HCVP (Figure 18). Notwithstanding the possible duplication, the data captured in Figures 17 and 18 suggest some degree of unmet need for affordable housing for eligible families with children birth though five.

Figure 18. **VIHA HCVP Waiting List by District for children B-5: CY2013–2014 – CY2017–2018**



Data Integration

In a *2018 State of Early Childhood Data Systems,* King, Perkins, Nugent & Jordan (2018) reported that fewer than half of states currently link child-level data to gain a comprehensive picture of early learning (22 states), social services (11 states), and children's health history (8 states) (pg.1). This result reflects responses from the 50 states to an Early Childhood Data Collaborative (ECDC) survey to assess states' capacity to link child-, family-, program-, and workforce-level data across ECE programs. The USVI was not included in the ECDC survey. Additionally, the Territory is among the jurisdictions without a comprehensive data system that links child-, family-, and program-level data to be able to follow individual children, programs, and staff across programs.

However, the Territory is working to bring together early childhood data to better organize and improve the use of existing data. In 2011 work began on an initiative, the Virgin Islands Virtual Information System (VIVIS) – the US Virgin Islands' B-20W State Longitudinal Data System (SLDS). VIVIS seeks to provide critical data to key stakeholders to help improve policy making by serving as a data warehouse that integrates data from the Departments of Education, Human Services, Finance, Justice and Labor, as well as LSSVI, and UVI. Early childhood education and health data, from programs and services supporting children B-5 would also be integrated in VIVIS to complete the Territory's longitudinal integrated data

system. In the initial phase, the data in VIVIS were projected to include data from K-12, higher education (UVI), and workforce, but not early childhood data. However, given the salience of early childhood data in a B-20 SLDS it was critical that early childhood data be included. To that end, in 2012, the USVI received funding for an Early Childhood Integrated Data System (ECIDS) from the United States Department of Education, Institute of Education Sciences (US ED IES) through an early childhood grant.

Although the Territory gathers substantial data about all early childhood services these data are not currently coordinated across programs. Work is ongoing to create an early childhood data system (ECIDS) and integrate ECIDS into VIVIS. However, to date an integrated data system in the USVI has not been fully implemented, in part, because of challenges associated with agencies and programs data that may be housed in different ways in different systems and, as such, data are not readily available or easily transferable to VIVIS. Additionally, legislation to sustain VIVIS and ECIDS activities and agreement on process for requesting and receiving data for research purposes are among some of the significant actions still outstanding.

While an integrated data system offers great potential to improve service delivery and outcomes for children, it is an expensive, multi-stakeholder undertaking. Data governance and inter-agency data systems operability issues are among the challenges facing VIVIS. Additionally, the absence of a culture of data sharing and extensive bottom-up evidence-based decision-making mean that, except for adherence to compliance requirements, individuals responsible for managing program data are sometimes unaware of how the data are used and by whom. Other challenges with ECE data include limited quality safeguards, human error, and the underutilization of existing electronic data systems. It was noted that without adequate back up capabilities a decision to change a data management provider may also result in the loss of historical data. *[KIs with data support personnel in the VIDE, Office of Special Education, December 2019; MCH & CSHCN Program; and Infant and Toddlers (Part C) Program, October 2019].*

Despite the important interplay between health and ECE, during the first five years of a child's life, the programs and services supporting children are often located in different agencies, providing services and activities in different contexts, and operating under different funding mechanisms. In the USVI, geography adds yet another dimension to these already

complex realities. Since the Territory is comprised of multiple islands, there is a need to duplicate all services across the three-island chain, which forms the two districts of St. Croix and St. Thomas-St. John. This has implications for the collection of data in a uniform manner and the cost associated with the duplication of both human and capital resources. Given these challenges, data may be available for one district but only partial or incomplete datasets or no data are available from the other district.

The availability and quality of data, on children birth through five, in the USVI must also contend with the lack of human resources to provide adequate data support services in respective agencies. There are several vacancies across the departments and agencies that provide services for children B-5 and their families. In HS alone, there were over 50 vacancies in SY 2018-19 (*FG discussions with HS supervisors and middle managers, October 2019*). Furthermore, some of these agencies still utilize paper-based record keeping practices or have a dual system that requires the transfer of data from paper to an electronic record. These practices have implications for data quality and in the wake of the recent hurricanes, that severely damaged many structures and destroyed records in the Territory, they have proven to be inefficient and have further contributed to the unavailability of data pertaining to the children birth through five.

III.5. Systems and Partner Collaborations and Supports

Data provided by key agencies that provide programs and services to the birth through five-year-old population in the U.S. Virgin Islands (USVI) suggest that there are multiple configurations of collaborations across the ECE mixed-delivery system in the USVI. In an effort to understand the scope, nature, and purpose of collaborations within the USVI's ECE MDS, key agencies in the Territory were asked to describe existing collaborations to support the delivery of programs and services for the B-5 population (and their families).

Lutheran Social Services of the Virgin Islands (LSSVI) receives funding to administer the Early Head Start Program (EHS) in the St. Croix District. The current funding covers a five-year period, FY2015-2016 through FY2019-2020 (LSSVI, 2015-2016 Annual Report). To support the delivery of the EHS program and related services, LSSVI receives support through several partnerships and collaborative agreements, described in annual reports under the umbrella of "community partnerships" (Table 5).

Table 5

Early Head Start (EHS) Community Partnerships, FY2017-2018

Collaborating Partner	Type of Partnership	Purpose of Agreement	Duration (if any)
American Red Cross – St. Croix	Partnership Agreement	To provide disaster preparedness support and training for EHS staff and parents	N/A
Frederiksted Health Care, Inc.	MOU	To provide primary care and dental services to EHS program participants receiving insurance through MAP	Updated SY2016-2017
Head Start Program [VIDHS]	Partnership Agreement	To provide transition information and tour (of HS facility) to parents of EHS children transitioning from EHS	N/A
Pediatric Care Center of the Virgin Islands	MOU	To provide primary care services to EHS children who are uninsured or need immediate assessment from a physician	Since SY2016-2017
V.I. Office of Highway Safety	Partnership Agreement	To provide safety and education training and education to EHS staff and parents	N/A

Source: LSSVI, EHS Annual Reports, 2016-2017; 2017-2018; 2018-2019

The community partnerships enumerated are either Memoranda of Understanding (MOUs) or partnership agreements. The stated goal of increasing community partnerships is to support the expansion services to EHS children and families, with special attention on father engagement. In addition to supporting the expansion of services, EHS works to engage various community entities in agreements that are supportive, encouraging and efficient, particularly in terms of securing timely receipt of needed health services for EHS children and

families, and ultimately, to ensure the overall well-being and improved attendance rate for center-based children.

EHS also documented the need for community collaborations to yield increased and improved communication with service providers, including therapists, engaged in the provision of developmental services for children with disabilities. These community collaborations are needed to address developmental concerns assessed, meetings with parents, EHS staff, and therapist to timely address children's needs (LSSVI, Annual Report 2018-2019). In three of the four annual reports reviewed, EHS described efforts to engage the VIDOH Infant and Toddlers Program in a formal collaborative agreement to work towards optimizing services to children and families with individualized family service plans (IFSPs), focused on addressing the needs of the child as well as the needs of the family. While efforts have been underway since SY2015-2016 to secure a formal agreement, EHS has indicated progress toward having a signed agreement by the end of FY2019-2020.

The Head Start Program (HS), administered through the Virgin Islands Department of Human Services (VIDHS) is the single largest ECE program in the USVI. Based on an environmental scan of the Territory's HS program (Michael, et al., 2016), several inter-agency and intra-agency agreements/partnerships, both formal and informal, support the delivery of services to HS children and families across the Territory. Most recently, in its 2018-2019 full-year Continuation Grant Application, the USVI Head Start (HS) program described various partnerships and collaborations that exist with other agencies and entities that support children and families of children who participate in HS (The U.S. Virgin Islands Department of Human Services Head Start Program Continuous Application 2018-2019).

One of the key agencies that the HS program collaborates with is VIDE around oral language development and transitioning HS children to the K-12 system. With respect to oral language development, the USVI HS program continues its partnership with VIDE with the implementation of the LAP-3 assessment that VIDE completes for HS children across the Territory. Test results are used by the HS program to develop targeted, individualized, developmentally appropriate activities for HS children around oral language. In the area of transitioning from HS to kindergarten, the collaboration that the HS program has with VIDE focuses on facilitating the transition process for HS parents through annual transition conferences. These transitional conferences provide key information that HS families need

relative to registering children for the K-12 system ahead of general registration dates. Families also receive information about the opportunity for their children to participate in Kinder Camp (limited space) for children to prepare for the transition from HS to kindergarten. Another benefit of the collaboration between HS and VIDE is the opportunity that HS parents/families have to register their children for Kindergarten at various HS centers, where their children attend. Additionally, through a Memorandum of Understanding (MOU), the HS program collaborates with VIDE and VIDOH to address services for children with disabilities as well as to identify children with disabilities who would be eligible for enrollment in HS.

The VIDE notes collaborations within the Territory's existing ECE MDS that support programs and services provided through the Granny Preschool program and special education services provided to children ages 3-5 through the Office of Special Education Program – Part B. More specifically, the Granny Preschool Program (GPP), currently offered at two elementary schools in the St. Croix District, has established multiple community partnerships to promote and sustain the GPP. Three partnerships exist in support of the GPP. First, VIDE partners with the only FQHC on St. Croix, Frederiksted Health Care, Inc., to ensure that students receive required vaccinations timely for registration eligibility, to facilitate program entry. Second, VIDE partners with VIDHS to provide preschool education opportunities to children on the HS waiting list unable to secure enrollment in HS, due to the cap of 894 federally funded slots. Further, to ensure appropriate adult to child ratio for the three-four-year-old children in GPP classrooms, VIDE receives support from the Senior Affairs Division that manages the Foster Grandparent program, to place Foster Grandparents in GPP classrooms to provide individualized support at one of the preschool sites. Finally, in support of the GPP, VIDE partners with Jobs for America's Graduates (JAG) to secure student interns, who receive job training and experience through internships in the GPP classrooms (one classroom per school and one intern per classroom).

Table 6 summarizes informal partner agreements that VIDE St. Croix School District has with VIDHS and VIDOH to support the B-5 population.

Table 6

VIDE Informal Partner Agreements with VIDHS and VIDOH

COLLABORATING PARTNER	PURPOSE OF AGREEMENT	DURATION (IF ANY)
Head Start Program [VIDHS]	To provide registration opportunities for HS sites	Annually, March - May
	Provide professional development on oral language development for teachers at Head Start	*See special note
	To decrease the number of students on the Head Start waiting list by enrolling students in the Granny Preschool Program once eligibility requirements were met	May 2017
Office of Childcare and Regulatory Services [VIDHS]	To procure licenses for the daily operation of the Granny Preschool Program.	Bi-annually
Department of Health	To provide clearance of enrollment for students registered in the Granny Preschool Program.	Annually, during open enrollment period
	To provide Granny Preschool parents with oral hygiene health tips and opportunities to sign up for on-site appointments for annual oral cleanings for preschoolers.	Granny Preschool implementation year

Source: VIDE Summary of Matrix of Agreements to Provide ECE services to children B-5, April 2020

With respect to the Part B program, VIDE noted only one existing, formal interagency agreement, which dates to 2015. That interagency agreement is between VIDE's State Office of Special Education (SOSE) – Part B and the VIDOH Infants and Toddlers Program – Part C. The purpose of the agreement is to ensure collaboration in the continuation of a statewide comprehensive coordinated interagency transition process of children exiting the Department of Health's Part C program who are referred, prior to age three, and found eligible for services under VIDE's Part B Program. The agreement is updated every three years.

The Maternal and Child Health and Children with Special Health Care Needs (MCH & CSHCN) Program in VIDOH leads efforts in the Territory to develop a comprehensive system of care and services for children birth through 21, as well as for pregnant women. The MCH & CSHCN program undertakes its responsibility through partnerships and collaborations with a wide range of entities – public/governmental, private, and non-profit. These collaborations and partnerships have been described by the MCH & CSHCN Program as integral to functioning within a coordinated system of preventive and primary health, thereby increasing the efficiency of the use of limited resources and optimizing the delivery of primary health care services.

With the MCH & CSHCN program, collaborations and partnerships that exist to support the delivery of services to children B – 5 are both formal and informal. Primarily, formal

collaborations exist with entities outside VIDOH and take the form of either Memoranda of Agreement or Interagency Agreements (IAs). The MOAs with the two FQHCs, the IAs with the two local hospitals and the Medical Assistance Program (MAP) (housed in VIDHS), have been established primarily for data sharing, recruitment, and referrals. The MCH & CSHCN program also coordinates with the hospitals to conduct and record results of health and hearing screening for newborns, track the result of genetic testing done in hospitals and provide follow up support with parents as needed. *(KI, Data Support Personnel, VIDOH MCH & CSHCN Program, December 2019).* There are plans to develop an MOA with VIDE for hearing and vision screening to be provided in the public school setting for the 5-year old population in kindergarten.

Currently, though the MCH & CSHCN program collaborates with EHS through an informal collaboration around data, services (hearing screenings), and recruitment, both entities are working on formalizing the collaborative relationship through an MOA. The other collaborations are primarily intra-agency and have been established to support data sharing, services, and/or referrals. Units within VIDOH that collaborate with the MCH & CSHCN program, to provide services that impact children, include the WIC program; immunization; nursing services, the Infant and Toddlers Program (Part C), and vital statistics.

In addition to its intra-agency collaboration with the MCH & CSHCN program, the WIC program also has inter-agency collaborations with the Head Start program, housed in VIDHS and with Lutheran Social Services of the Virgin Islands (LSSVI). The MOU between WIC and HS was entered into in December 2010 and is intended to improve service delivery for children eligible to participate in both programs. The idea is to enhance program coordination and service delivery, particularly around common goals related to the provision of nutritious meals and nutrition education. The MOU also speaks to collaboration relative to parent education in the areas of decision-making regarding children's physical and emotional well-being. As written, the MOU does not have an end date, but could be reviewed and or modified if either program or agency determines that review and/or revision was needed. The MOU with LSSVI, with an effective date of May 2013, focuses on the provision of access to WIC benefits, as allowable by federal guidelines, to institutionalized participants, to include children. Qualified institutionalized participants would be entitled to the same WIC benefits as

non-institutionalized, qualified persons. Like the MOU between WIC and HS, there is no end date for the MOU between WIC and LSSVI.

In characterizing the agreements that currently exist between and among key agencies that deliver programs and services to the B-5 population in the USVI, one agency head noted,

> *I think that they need to be enhanced, to be honest with you… I would say that we have to kind of take a look and see how old they are… So I think that we need to kind of take a look at the services across the board in the Virgin Islands, see, make sure that we're not duplicating services, and making sure that we're doing it most efficiently in the best interest and best practices for our parents.* [KI, Head, PAOS, August 2019]

There was also a recognition that one of the areas in which new arrangements and partnerships could be fostered to better meet the needs of children B-5 would be with respect to wrap-around services. One partner agency head shared that

> *I think wraparound services to families in general. I think that sometimes we're in silos that are providing a service, but I think if we all work together to make sure that there's no gaps in the service. …So if you look at seven year olds going to school …, there might be a four year old … a three year old and a two year old …, what … are you doing* [through] *a wraparound services program to ensure that the whole family's taken care of? So, I think that that's probably something we can do better.* [KI, Head, PAOS, August 2019]

Within the Territory's ECE MDS, there is no agency or entity that owns or manages a repository of existing intra-agency agreements or collaboration documents. In most instances, for the information presented in this section of the Needs Assessment, summary information was provided relative to the purposes of existing collaborations or agreements; however, the specific terms of these agreements were not available for review and most agreements and/or collaborations referenced appear to be informal rather than formal. This gap provides an opportunity to develop a repository of current Interagency Agreements, Memoranda of Agreements and Understanding, as well as other collaboration mechanisms that providers and policy makers can access to better understand how the USVI's ECE MDS works and which entities may be able to support and help strengthen the Territory's ECE MDS.

III.6. Quality and Availability of Programs and Supports

This section of the Needs Assessment highlights current strengths of ECE in terms of quality of care across settings, availability of quality ECE programs, and supports that are in place to support families who access ECE programs in the U.S. Virgin Islands. This section will also address gaps in quality of care across settings as well as opportunities for the Territory to improve the quality and availability of ECE programs and supports, particularly for vulnerable and underserved children and families of children B – 5 in the USVI. The information presented in this section of the Needs Assessment is anchored in administrative and secondary data sources as well as from primary data sources. With respect to primary data, results from teacher and parent surveys are presented after the summarization of data from secondary and administrative data sources.

Quality as evidenced by licensing of childcare facilities

One of the *foundational elements of quality is the licensing of childcare facilities*. In the U.S. Virgin Islands, the VIDHS is responsible for licensing childcare facilities. The Office of Childcare and Regulatory Services (OCCRS) within VIDHS carries out this responsibility. The licensing process adheres to a set of licensing regulations that are set forth in the 2011 document, Rules and Regulations for Childcare Facilities, After School Programs, and Summer Camps. More specifically, childcare facilities must meet required standards in the following areas:

- General administration,
- General qualifications of staff and directors,
- Health rules and regulations,
- Fire, health, building and safety,
- Staff, program, and facilities, and,
- Food service and nutrition.

Currently, there are 45 licensed childcare facilities in the St. Croix District and 68 licensed childcare facilities in the St. Thomas-St. John District. Figure 19.1 captures the number of licensed childcare facilities across the Territory that serve only children B-5 and the facilities that serve a wider age group, with a few serving children as young as toddlers and as old as 15. In the B-15 category, there is a range in terms of the number that serve children older than five years of age. These numbers are as of SY2019-2020 – the most recently available capacity and enrollment data.

Figure 19.1. **Licensed childcare facilities serving children B-15: Territory and Districts, SY2019-2020**

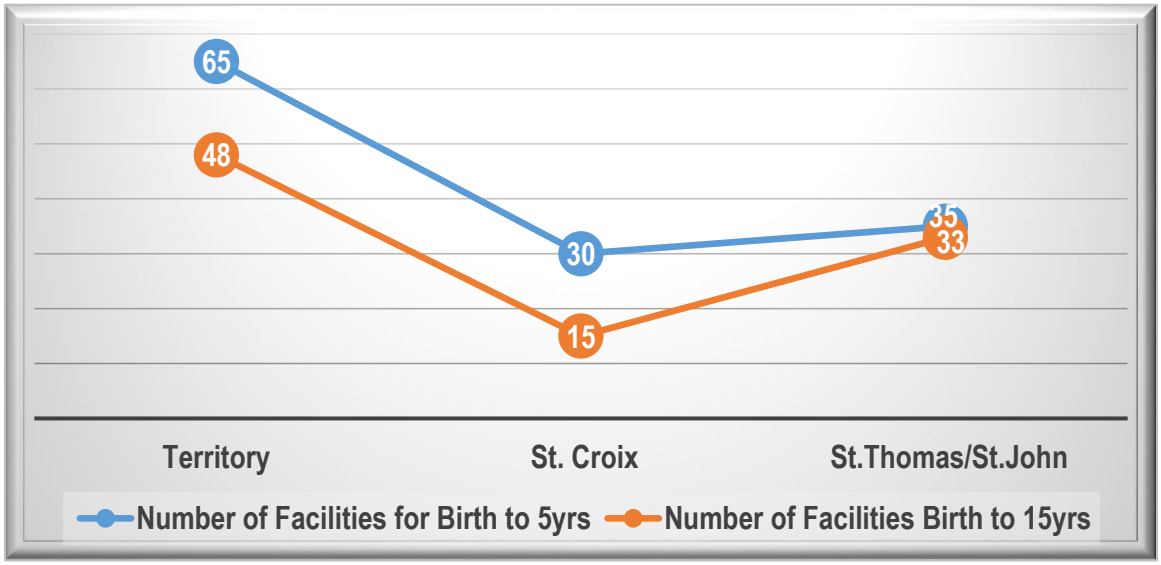
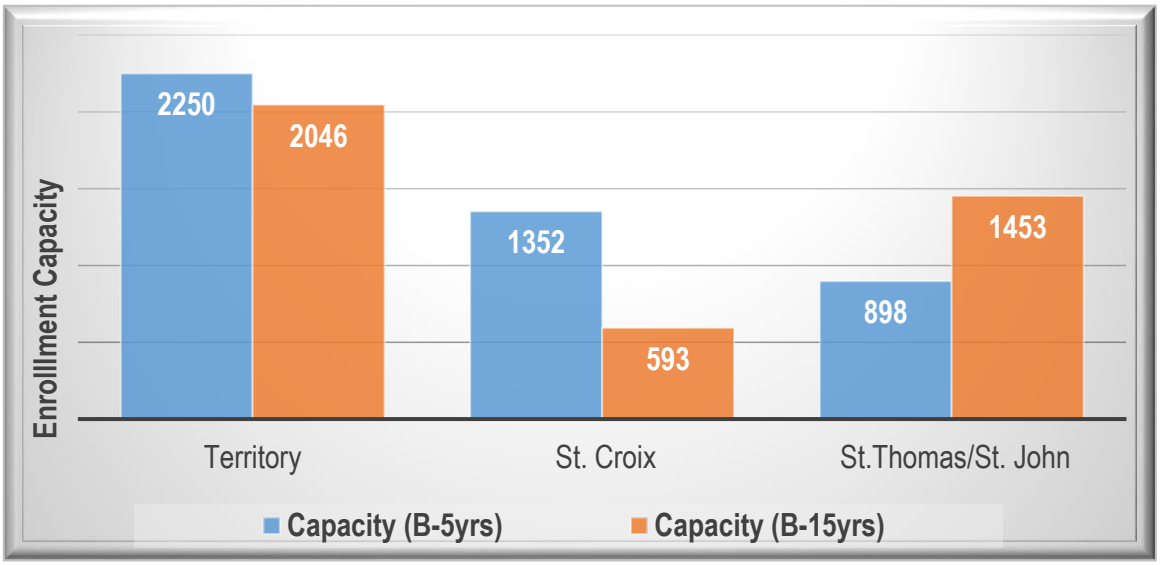


Figure 19.2 captures information on enrollment capacity of licensed childcare facilities across the Territory. Of note is that while the St. Thomas-St. John District has a larger number of licensed childcare facilities exclusively for children B-5 (Figure 19.1), the St. Croix District has more enrollment capacity for this age group – 1,352 enrollment slots compared to 922 slots in the St. Thomas-St. John District (Figure 19.2). Yet, since the facilities that service the broader age group, B-15, also serve children B-5, it is likely that enrollment capacity for children B-5 across the Territory may be close to 3,000, given that overall enrollment capacity for all facilities across the Territory for children B – 15, inclusive is over 4,000.

Figure 19.2. **Enrollment Capacity of Licensed Childcare Facilities Serving B-5 and B-15 Children: Territory and Districts, SY2019-2020**



Programs/Supports for Children B-5 and for Parents of Children B-5

With respect to *programs/supports that help connect children, B-5, to appropriate, high-quality care and education*, there are Head Start (HS) programs and licensed private and organizational Day Care Centers in both districts, and an Early Head Start (EHS) and Granny Preschool programs in the St. Croix District. The Territory developed a graduated quality standards program, Virgin Islands Steps to Quality (VIS2Q), based on the Quality Rating and Improvement System (QRIS), and HS teachers/providers are required to have 15 hours of professional development annually. In terms of weaknesses, the number of HS Centers declined after the 2017 hurricane season. Additionally, except for a limited piloting of the VIS2Q in 2016, the Graduated Quality Standards has not been fully implemented. The Office of Childcare and Regulatory Services (OCCRS) is currently in the process of reviewing and revising the Virgin Islands Quality Rating and Improvement System (QRIS): VI Steps to Quality (VIS2Q) for Early Care and Education Programs, though a timeframe for the implementation of the revised VIS2Q has not been determined *(Communication from VIDHS Acting Director of Quality Services, April 2020)*.

With respect to *programs/supports for parents who are employed, looking for work, or in training who need to access childcare*, there is a Temporary Assistance to Needy Families (TANF) program Territory-wide that provides job training and placement. The TANF Job Opportunities and Basic Skills (JOBS) program, in the Department of Human Services, collaborates with the Department of Labor and the Department of Education's Vocation and Adult Education programs. However, the JOBS program has difficulty identifying job opportunities for TANF clients. Other challenges include the lack of reliable transportation. Transportation is provided for families served by the EHS programs on St. Croix. Yet, while vehicles are available for some clients, there are inadequate resources to maintain the vehicles (Personal communication, EHS Program Director, August 2019).

Programs/Supports or Developmentally Delayed Children, B-5

In the area of programs/supports *to identify children who are developmentally delayed and connect them to service*, Virgin Islands standards require individualization for special populations of children, coordination with specialized services, and written policies on implementation of Individualized Education Plans (IEPs) or Individualized Family Services Plans (IFSPs). The VIDHS coordinates with the Virgin Islands University Center for

Excellence in Developmental Disability (VIUCEDD), the Virgin Islands Department of Education -Special Education Division, and the Department of Health - Infants and Toddlers Program, to support children with disabilities and their families. This coordination assists in the transition of children from early care and education/pre-k settings into the K-12 system with identified support as described in the VI 2018-2021 CCDF State Plan.

VIDE administers the Individuals with Disabilities Education Act (IDEA) Part B (Preschool Special Education) and VIDOH administers Part C (Birth to 3). The Head Start (HS) and EHS programs utilize the 'Ages and Stages' questionnaire screening and EHS also administers the Ages & Stages Questionnaires: Social-Emotional Development Screening Tool (ASQSE). VIUCEDD provides services for persons with disabilities. The VIDOH Infants and Toddlers Program [Part C] (ages 2 ½) interfaces directly with parents/guardians of children referred for possible services. In describing how Part C supports parents of children needing Part C services, the program administrator noted referrals provided by nurse practitioners who work with mothers and their young children and what happens during the initial intake visit, which includes scheduling the appropriate provider – developmental specialist, physical therapist, or speech therapist to evaluate the child.

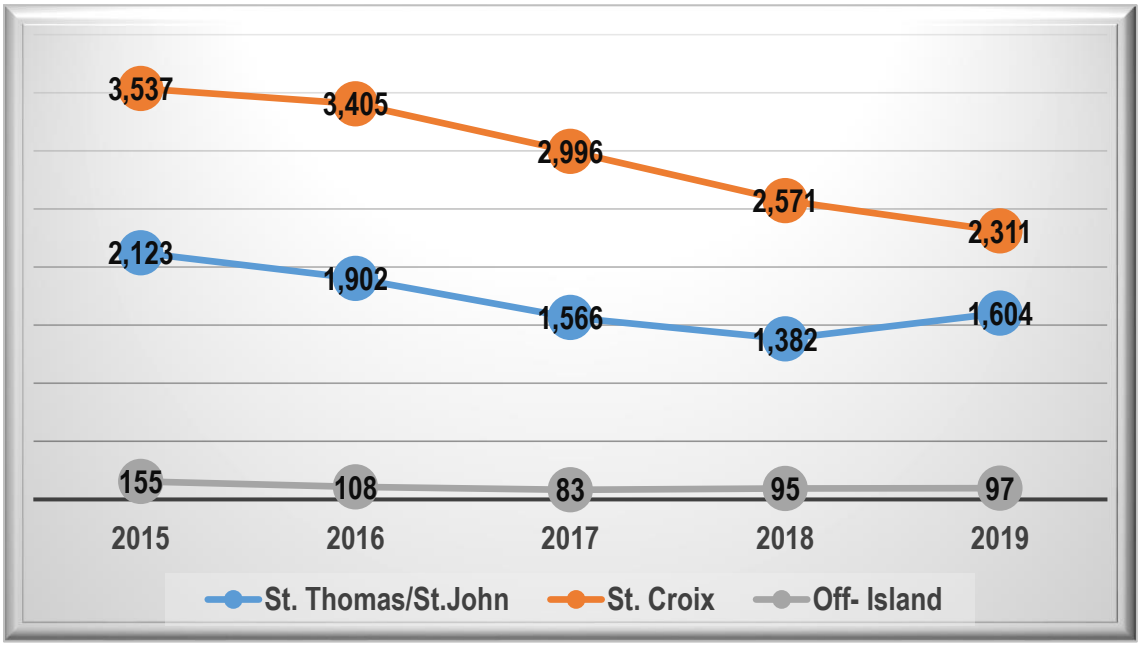
> *…the Family Nurse Practitioner program … it's for first-time moms. They do have visits and they help with caring for the baby, and teaching parents how to work with their baby. …we get referrals from the family nurse practitioner. …after they get referred to the program, I'm the first person that they meet because I do the intake. I gather the background information, I explained the process, the purpose and how the program works. From me then, they need a provider who do the evaluation. .* [KI, Data Support, Part C; August 2019]

The VIDE State Office of Special Education (SOSE) [Part B] (age 3-5) oversees the direct provision services to this population at HS, EHS, private childcare centers, and to a limited extent, in homes by VIDE's District Offices of Special Education (DOSE) in the St. Croix and St. Thomas-St. John Districts. The EHS program has a full-time staff manager to track students' development and make appropriate referrals. There are wait-time issues with obtaining services from VIDE, and the US Department of Education (ED) has determined that the VIDE needs assistance in implementing the requirements of Part B of the IDEA as communicated in correspondence to the Chief State School Officer dated June 2019 (2019 Determination Letters on State Implementation of IDEA).

Programs/Supports for Vulnerable and Underserved Children, B-5

Various programs/supports are available that help ensure early care and education settings help vulnerable or underserved children access needed support services such as health care, food assistance, housing support, and economic assistance. Health care is supported by the Medical Assistance Program (MAP) for those who qualify financially. All central government and semi-autonomous government health facilities and programs (VIDOH, FQHCs; hospitals) in the USVI accept Medicaid and provide services to children birth through five whose health care is covered through the Territory's Medicaid Child Health Insurance Program (CHIP). Figure 20 provides a snapshot of the number of children across the Territory who received support through MAP over the past five fiscal years.

Figure 20. **Children in the USVI Whose Healthcare was Covered by MAP: FY2014-2015 to FY2018-2019**



In the USVI, several programs support the provision of other basic needs such as food and shelter. Food assistance is available through the Department of Human Services (VIDHS) SNAP, the Department of Health (VIDOH) administers the WIC program, and the VIDE school breakfast and lunch programs that provide free or reduced meals to the HS/EHS programs and some private childcare centers, as well as all public, private, and parochial schools serving children who qualify for the programs. Economic assistance is available through the VIDHS TANF program. Catholic Charities operate homeless shelters in both districts. There are challenges related to housing availability, particularly after the major damage to public

housing units by the 2017 hurricanes, resulting in 'couch surfing' to others' homes (Catholic Charities Testimony, February 2019 (Bourne-Vanneck, 2019).

There are limited numbers of providers of health services (for children B-5), particularly in the areas of dentistry and behavioral health. In 2019, to address the challenges surrounding engaging behavioral health professionals, Governor Albert Bryan Jr. signed Executive Order 486-2019 in which he declared a mental healthcare emergency and delineated the Administration's approach to improving behavioral health services across the Territory. The two FQHCs in the Territory are also working to address behavioral health needs for their clients. The team learned from key informant interviews that current staff include an adult and pediatric psychologist and psychiatrist, as well as a doctoral level social worker who supports behavioral health. Further, services are projected to be expanded with the addition of two caseworkers in the near future (KI, CEO FQHC; September, 2019). To date, there is no evidence that the Governor's Executive Order has resulted in the addition of behavioral health providers within the Department of Health, Division of Behavioral Health, Alcoholism and Drug Dependency Services (BHADDS), that would improve access to behavioral health services for the poor and uninsured. Additionally, most private dental and behavioral health providers do not accept Medicaid/Medicare insured patients because of the low reimbursement rate for these patients (USVI Hurricane Recovery and Resilience Task Force 2018. Subheading Health Insurance pg. 73).

Programs/Supports for Dual Language Learners

In the area of *programs/supports available to support children who are non-English speakers or reflect different cultures that connect them to services*, Federal standards for culturally and linguistically appropriate communication guidelines are in place for HS/EHS programs. The VIDE has an English as a Second Language (ESL) program. There are Spanish-speaking staff available at most HS and EHS Centers, and the EHS program has an Arabic speaker. In addition to having bilingual staff, the two FQHCs in the Territory also utilize a language service to support and ensure the privacy of parents of non-English speaking populations in the Territory (*KIs, Heads, FQHCs, September 2019*). However, there are some challenges having translators available for parents, when needed. Private childcare facilities hire bilingual staff when possible (*FG, Owners & Operators, Private childcare facilities, March 2020*).

Programs/Supports to Address Behavioral Health Needs

In the area of *program/supports available that help ensure early care and education settings are able to connect families in crisis to needed programs or services* (e.g., family violence programs, emergency economic assistance, mental health care, substance abuse treatment), there are NGOs in both districts that actively support persons who are victims of domestic violence, including shelter and emergency funds. The FQHCs and the VIDOH BHADDS program provide mental health and substance abuse treatment. An NGO in the St. Croix District provides residential substance abuse treatment. The hospital in the St. Thomas District provides in-patient behavioral health services. There are no in-patient behavioral health hospital beds on St. Croix and there are limited numbers of private mental health services' providers who accept MAP. There are no public providers who specialize in child psychiatry. The VIDOH BHADDS program provides limited behavioral health services for persons under age 12.

Quality with Respect to Teacher/Caregiver Qualifications and Preparation

One of the markers of quality is the qualification of caregivers in the ECE MDS. For the HS and EHS programs, there are credentialing requirements that are imposed by the Administration for Children and Families in the Head Start Program Performance Standards with respect to certifications by teachers and assistant teachers. Based on data reported in the Program Information Report (PIR) submitted annually by the HS and EHS programs in the USVI, HS/EHS teachers and assistant teachers meet the qualification requirements. Additionally, for childcare facilities licensed by the V.I. Department of Human Services, credentialing requirements that owners/operators as well as teachers and assistant teachers must possess are delineated the 2011 Revised Rules and Regulations document that governs the licensure process (VIDHS, *Rules and Regulations for Childcare Facilities After-School Programs Summer Camps, 2011*).

Head Start/Early Head Start

Based on the most recent data reported in the Program Information Reports (PIR) submitted by the HS and EHS programs in the USVI, as required, all teachers and assistant teachers meet the minimum requirements with respect to academic credentials. As can be observed from Figure 21.1 (Head Start teachers) and Figure 21.2 (Head Start assistant teachers), this marker of quality has been met by HS and EHS teachers and assistant

teachers for school years 2015-2016 through 2018-2019. Yet, as can be observed from Figure 21.1, there were at least 33% fewer HS teachers with a BA degree or higher in ECE in SY2018-2019 than there were in SY 2015-2016. There was a reduction of 10% in the number of teachers in SY2018-2019 compared to the number of teachers in SY2015-2016.

For HS assistant teachers, a review of Figure 21.2 shows that all HS assistant teachers either held CDAs or AA degrees or were enrolled in a CDA/AA program. Also of note is that with the exception of SY2015-2016, when there were fewer assistant teachers than HS classrooms, for the other years, there was either a one-to-one ratio of assistant teachers to HS classrooms, or, more assistant teachers than HS classrooms – 14 more assistant teachers in SY2018-2019 than HS classrooms. This occurred in part due to the consolidation of classrooms on St. Thomas with the destruction of the Minetta Mitchell HS Center or the continued closure of two HS centers on St. Croix, also destroyed by Hurricanes Irma and Maria in September 2017. For EHS, a program only available in the district of St. Croix, based on PIR reports, all EHS teachers and assistants met teacher qualification requirements, specifically, having a CDA or an AA degree in Early Childhood Education.

Figure 21.1. **HS Classrooms, Teachers, and Teacher Qualifications: SY2015-2016 - SY2018-2019**

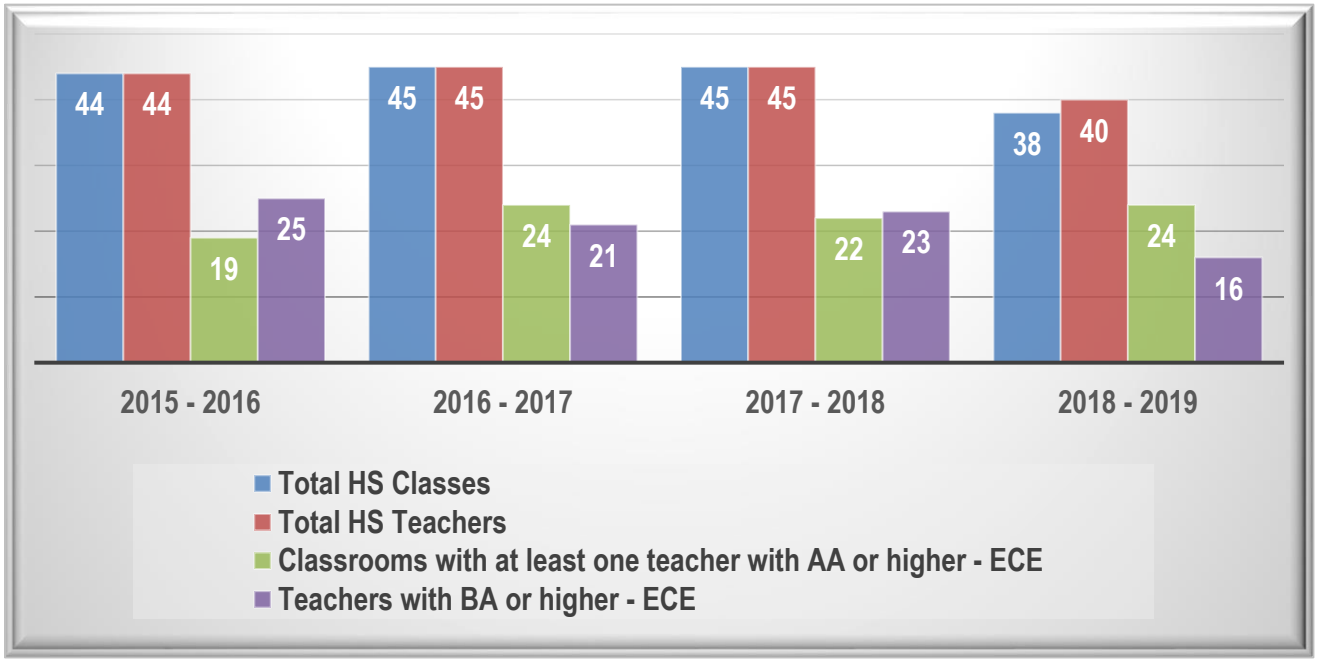
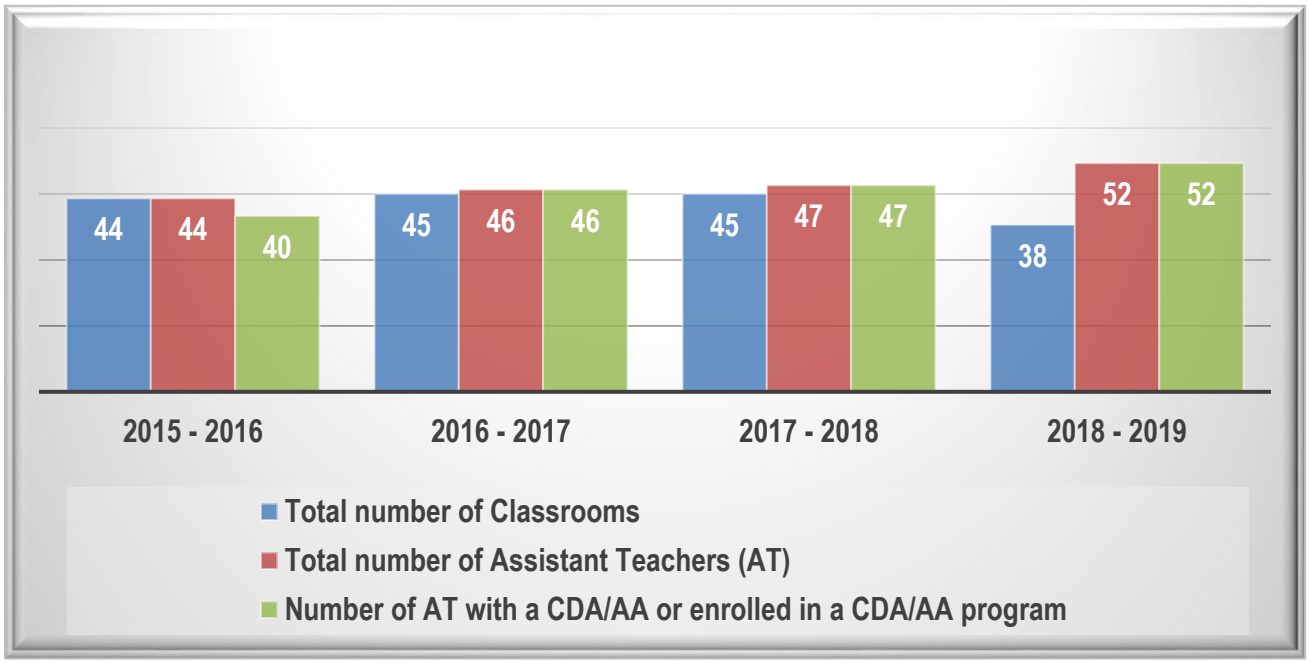


Figure 21.2. **HS Classrooms and Assistant Teachers with Required Credentials: SY2015-2016 - SY2018-2019**



Granny Preschool & Kindergarten [K-12 public education system]

With respect to teachers in the Granny Preschool and Kindergarten programs in the public K-12 system under the auspices of the Virgin Islands Department of Education, all teachers have a minimum of a Bachelor of Arts degree in Elementary Education. (V.I. Department of Education, 2019)

Other Licensed Childcare Facilities [Daycare centers and preschools]

As noted above, the rules and regulations that govern the licensure of childcare facilities across the Territory delineate credentialing requirements for the director and teaching staff. However, unlike HS, EHS, and Granny Preschool and Kindergarten programs for which data were readily available relative to the proportion of staff that meet the credentialing requirements, there was no available data for the childcare facilities licensed by the VIDHS. This gap provides an opportunity to develop a repository or database of early childhood caregivers across the Territory, as work moves forward on strengthening the Territory's ECE MDS.

Quality with respect to Caregiver Knowledge and Beliefs about Language and Literacy Development: Teacher Survey

Recognizing that access to high quality ECE providers is a measure of access to quality and availability of programs and supports in the USVI ECE MDS, this section of the Needs Assessment presents findings from a teacher survey administered to ECE providers that work in day care centers, preschools, Head Start centers, and Early Head Start centers in the U.S. Virgin Islands. This survey was included in the Territory's ECE MDS Needs Assessment to ensure that the information on ECE providers reflect as diverse a group as possible.

The next three tables capture information on several characteristics of the ECE caregivers who completed the caregiver survey. As noted from Table 7.1, the typical caregiver/teacher respondent was a Black, non-Hispanic female, 50 years of age or older.

Table 7.1

Demographic Characteristics of Caregivers/Teachers

CHARACTERISTIC	CATEGORY	NUMBER (PERCENT)*
Age group	18 - 29	27 (12.4)
	30 - 39	38 (17.4)
	40 - 49	57 (26.1)
	50 and Older	**96 (44.0)**
Sex	**Female**	**213 (96.8)**
	Male	7 (3.2)
Race	**Black**	**181 (85.0)**
	Other	32 (15.0)
Ethnicity	Hispanic	25 (12.3)
	Not Hispanic	**179 (87.7)**

**Note: Percentages are based on the number of caregivers/teachers responding to an item. n=221*

Further, the typical caregiver/teacher who completed the survey was a single/never married female in a two-person household, with at least one child between the ages of birth and five years old in the family (Table 7.2).

Table 7.2

Caregivers'/Teachers' Family Composition

CHARACTERISTIC	CATEGORY	NUMBER (PERCENT)*
Marital Status	**Single, never married**	**101 (45.7)**
	Married	82 (37.1)
	Divorced	21 (9.5)
	Other (domestic relationship; separated or widowed)	17 (7.7)
Family Size	**2**	**73 (35.3)**
	3	53 (25.6)
	4	39 (18.8)
	5 or more	42 (20.3)
Children B-5 in Family	None	154 (71.0)
	1	**35 (16.1)**
	2	15 (6.9)
	3 or more	13 (6.0)

**Note: Percentages are based on the number of caregivers/teachers responding to an item. n=221*

Finally, the typical caregiver/teacher who completed the teacher survey had insurance through her job, held a BA/BS degree, or higher, yet earned less than $35,000 annually, though employed full-time (Table 7.3). Table 7.3 also reveals that three in 10 caregivers in private, licensed childcare facilities have not met the CDA/AA credentialing requirements.

Table 7.3

Socio-economic Characteristics of Caregivers/Teachers

CHARACTERISTIC	CATEGORY	NUMBER (PERCENT)*
Educational Attainment	Less than HS Diploma	4 (2.0)
	High School Diploma/GED Certificate	53 (27.0)
	CDA/Some college/AA	38 (19.4)
	BA/BS or higher	**101 (51.5)**
Employment Status	**Employed, full-time**	**201 (91.4)**
	Employed, part-time or self-employed	14 (6.4)
	Unemployed	0 (0)
	Other (retired or 'other')	5 (2.3)
Household Income	**Less than $35,000**	**104 (48.1)**
	Less than $50,000	49 (22.7)
	Less than $75,000	22 (10.2)
	$75,000 or greater	10 (4.6)
	Not sure	31 (14.4)
Type of Insurance	**Private, through job**	**132 (61.4)**
	Public (Medicaid or Medicare)	32 (14.9)
	Uninsured	27 (12.6)
	Other (self-insured or 'other')	24 (11.2)

**Note: Percentages are based on the number of caregivers/teachers responding to an item. n=221*

The data characterizing ECE caregivers/teachers appear to identify a group that could border on being in the vulnerable population despite educational attainment levels and full-time employment status. According to a study published by the U.S. Virgin Islands Bureau of Economic Research (2016), the self-sufficiency standard for a family of one adult and one child in the USVI is $36,853, and $54,250 for a household with two adults and one child.

Summary of Language and Literacy Knowledge items

Teachers responded to two sets of questions that assessed their language and literacy knowledge. Part I of the survey comprised 50 multiple-choice items and Part II comprised 20 true-false items. Because the language and literacy questions were scored as either correct or incorrect, skipped items were scored as incorrect, so theoretically, there was no missing data in these two sections of the survey. For Part I, the maximum score could have been 50, if all questions were answered correctly and for Part II, the maximum score could have been 20, if all questions were answered correctly.

For the 221 caregivers and teachers who completed the survey, summary caregiver/teacher performance, as well as the reliability of these two sections of the survey are captured in Table 8, below. The summary information on caregivers'/teachers' language and literacy knowledge is not strong, based on average number correct on Part I (mean = 33) and Part II (mean = 11) of the survey. Reliability of the composite score (alpha=.86), as well as the reliability for Part I, the 50-item, multiple choice section (alpha=.83) were very good. As expected, the 20 true-false items had acceptable reliability at alpha=.71. It should be noted that, in the literature, Parts I and II of the instrument are reported as a composite score and the reported reliability ranges from alpha=.78 to alpha=.96 (Ottley, J.R., Piasta, S.B., Mauck, S.A., O'Connell, A., & Justice, L.M., 2015).

Table 8

USVI ECE caregivers'/teachers' language and literacy knowledge

	Mean (SD)	Median (Mode)	Std. Error of Mean	Reliability (α)
Composite	32.61 (9.83)	33.00 (32.00)	0.66	**0.86**
Part I	21.53 (7.50)	22.00 (20.00)	0.50	0.83
Part II	11.08 (3.51)	12.00 (12.00)	0.16	0.71

Caregivers'/Teachers' performance on the Language and Literacy Knowledge section of the survey provides evidence of the need for targeted professional development that would

be beneficial for the full range of ECE caregivers and teachers in the US Virgin Islands and that could be integrated into the annual required training.

Teachers Beliefs and Values

Part III of the Caregiver/Teacher Survey comprised 20 items measured on a Likert scale, with response options ranging from Strongly Disagree (SD) to Strongly Agree (SA), and the middle response option being "Neutral". For these items, between 12 and 21 participants skipped one or more of the questions. Respondents rated their confidence in their ability to support children in their development of early reading, language, and writing skills. Responses to these items contrasted greatly to teachers'/caregivers' overall performance on Parts I and II of the survey (Table 8).

Table 9.1

Caregiver/Teacher confidence in supporting the development of children's language, reading, and writing skills

I AM CONFIDENT …	STRONGLY AGREE OR AGREE NUMBER (PERCENT)
That **I can motivate all of the children** in my care **to read or look at books regularly**.	180 (86.5)
In my ability to support the early reading and writing skills of all of the children in my care.	179 (85.6)
That I can teach all of the children in my care to recognize letter sounds.	175 (84.1)
That I can help all of the children in my care make significant progress in their language skills this year.	172 (83.1)
That I can teach all of the children in my care all their alphabet letters.	168 (81.6)
That I can help all of the children in my care develop early writing skills	165 (78.9)
That I can teach all of the children in my care to recognize rhymes.	149 (72.4)
That I can help children whose first language is not English make significant progress in their language skills.	125 (61.9)

A perusal of Table 9.1 shows that the majority of caregivers and teachers reported being confident in supporting the development of the language, reading and writing skills of children in their care, with the highest percentage expressing confidence in motivating children to read or look at books regularly. Similarly, over 80% of caregivers/teachers also felt confident in helping all children in their care develop language and learning the alphabet. Of note, however, is that when queried specifically about helping children whose first language is ***not*** English develop their language skills, fewer than two-thirds (62%) expressed the same level of confidence.

Table 9.2 captures caregivers'/teachers' responses to items that signal their values and openness to growth opportunities with respect to better supporting the development of the

language, reading, and writing skills of children whom they teach. Detailed responses to all 20 items are included in Appendix V. As can be observed, the first three items focus on the development of children's early reading and writing skills. For all items, most caregivers, and teachers (90% to 94%) agree or strongly agree on the importance of fostering children's early reading and writing skills and the usefulness of learning new ways to support this learning. Considering children's language development, though just over one-third of caregivers'/teachers' view supporting children's language development as more important than other teaching skills, over 90% would like to learn more about supporting children's language development and just about 8 in 10 value having a better understanding of children's early language development.

Table 9.2

Caregiver/Teacher values and openness to growth opportunities in support of the development of children's language, reading and writing skills

ITEM	STRONGLY AGREE OR AGREE NUMBER (PERCENT)
Being a caregiver who can foster children's early reading and writing skills is important to me.	188 (90.4)
Learning new ways to support children's early reading and writing skills would be useful to me.	196 (93.2)
I enjoy learning about new ways to teach early reading and writing skills.	196 (93.8)
Being able to support children's ***language development*** is ***more important to me than other teaching skills***.	74 (37.0)
I am interested in learning more about how to support children's language development.	188 (90.9)
I would value having a better understanding of children's early language development.	168 (82.0)

So, while caregivers and teachers express confidence in teaching children early language, reading and writing skills, they also acknowledge interest in and the benefits that could be derived from better understanding children's early language development and acquiring additional skills in teaching reading and writing skills to the children they serve.

Quality with respect to Curriculum

Head Start and Early Head Start

Both the Head Start and Early Head Start programs in the U.S. Virgin Islands utilize the HighScope Preschool Curriculum (HSPC) – HS and the HighScope Infant-Toddler Curriculum (HSITC) – EHS. A 2017 HighScope Preschool Curriculum review available through the Head Start Early Childhood Learning & Knowledge Center on ACF's website assessed the curriculum on nine criteria and found that on seven of the nine criteria, there was full evidence available to demonstrate that the curriculum meet those criteria, specifically:

- ✓ *Criterion 2* -- The curriculum provides research-based content and teaching practices to support children's development and learning.
- ✓ *Criterion 3* – The curriculum includes an organized developmental scope and sequence to support children's development and learning.
- ✓ *Criterion 5* – The curriculum specifies learning goals for children.
- ✓ *Criterion 6* – The curriculum provides guidance on ongoing child assessment.
- ✓ *Criterion 7* – The curriculum promotes parent and family engagement.
- ✓ *Criterion 8* – The curriculum offers professional development and materials to support implementation and continuous improvement.
- ✓ *Criterion 9* – The curriculum promotes rich learning experiences to support development across domains.

For Criterion 1, *Evidence from research demonstrates that the curriculum has been associated with children's positive learning outcomes*, the reviewers gave a rating of "minimal evidence" since most of the studies cited in the HighScope documentation were conducted in the 1960's based on an older version of the curriculum. For Criterion 4, *The curriculum is aligned with the* Early Learning Outcomes Framework, revised by ACF in 2015, the reviewers gave a rating of "moderate evidence", noting that only partially addressed the sub-domain, Health, Safety, and Nutrition (pp. 1-3). A similar review was done of the HighScope Infant-Toddler Curriculum based on 14 criteria. Six criteria were assessed as providing "full evidence" based on the curriculum and related resourced reviewed; six criteria were assessed as providing "moderate evidence"; and two criteria were assessed as providing "no evidence" to show that the curriculum met the criteria, specifically, *Criterion 1: Evidence from research demonstrates that the curriculum has been associated with children's positive learning outcomes* (no studies done to link children's outcomes with the curriculum) *and Criterion 12: Linguistic Responsiveness* (intentional focus on language development for Dual Language Learners is not evident).

Overall, the reviews of both the HSPC and the HSITC demonstrate the fidelity of both curricula that are currently being used by the USVI HS and EHS programs. The observations that studies are needed to link the curriculum to children's outcomes provide an opportunity for the USVI to engage in this research as the Territory moves forward to strengthen its ECE MDS. Documenting these linkages would, by extension, contribute to the literature.

While information on the curriculum used in the HS and EHS programs was readily available, similar data were not readily available through any type of repository for private day care centers, other childcare facilities, or private and parochial preschools across the Territory.

These facilities are not required to submit annual reports that could possibly capture information similar to data that HS and EHS must submit as part of their annual PIR. Yet, the Revised Rules and Regulations that govern the licensure of private childcare facilities, require that facilities have a program that meets the basic development needs of enrolled children. This requirement is to be operationalized through written plans of daily activities that reflect enrolled children's ages, abilities, and interests.

During focus group discussions, some owners/operators and/or directors of childcare facilities discussed the use of a creative curriculum as well as focusing on nurturing and the development of socialization skills. The quotes below provide capture these sentiments:

> *… we feel that children learn through play, so there's a lot of play that goes on in the course of the day, but we also follow a lot of the creative curriculum. So, we're looking at the social, emotional development, motor skills – all that kind of stuff. But a lot of the kids don't even know it's a lesson; they feel like it's play.*
>
> *… to be honest, a lot of the things that … we pay close attention to is making sure that our socialization skills with our students are up to par, because we do have a lot of students that come in and they're the only child in the home. … I think that a lot of the schools that are open right now are more focused on just nurturing, and just kind of taking care of a child throughout the day … the fine motor skills, communication, socialization … talking and walking …* [FG, Childcare Facility Owners/Operators; March 2020]

Quality from Parents' Points of View: Parent Survey

According to a National Survey of Early Care and Education (NSECE) Survey Summary Brief 3 (2012), historically, there has been a dearth of nationally representative data that describe the decision-making process parents use when seeking early care and education (ECE) arrangements for their children. This section provides information on parents' perspective of the quality of early childcare and education in the Territory, based on their experiences with the system. A total of 159 parents with children in HS, EHS, and private childcare facilities across the St. Croix and St. Thomas-St. John Districts completed the parent survey, with 52% or 83 identifying as St. Croix residents and 4% (7) identifying as St. John residents. Tables 10.1, 10.2, and 10.3 summarize key parent sociodemographic characteristics.

Table 10.1
Demographic Characteristics of Parents/Guardians

CHARACTERISTIC	CATEGORY	NUMBER (PERCENT)*
Age group	18 - 29	55 (35)
	30 - 39	**66 (42)**
	40 - 49	27 (17)
	50 and Older	11 (7)
Sex	**Female**	**137 (86)**
	Male	22 (14)
Race	**Black**	**137 (87)**
	Other	22 (13)
Ethnicity	Hispanic	31 (20)
	Not Hispanic	**127 (80)**

**Note: Percentages are based on the number of persons responding to an item. n=159*

Table 10.1 captures select demographic characteristics of the parents who completed the parent survey and reveals that the typical parent respondent was a Black, non-Hispanic female between 30 and 39 years of age. While two in five parents were between the ages of 30-39, just over one in three reported being between 18 and 29 years of age.

With respect to the family composition of the parents who completed the survey, the majority (66%) were single, with at least one child B-5 in the household (Table 10.2). Additionally, one in three families had four members while one in three had five or more members. When one considers that approximately two-thirds of families have four or more members, and approximately 57% of parents reported incomes less than $35,000, it is clear that the majority of parents accessing the USVI ECE system in the Territory are not self-sufficient (V.I. Bureau of Economic Research, 2016).

Table 10.2
Parents'/Guardians' Family Composition

CHARACTERISTIC	CATEGORY	NUMBER (PERCENT)*
Marital Status	**Single, never married**	**105 (66)**
	Married	39 (24.5)
	Divorced	7 (4.4)
	Other (domestic relationship; separated; widowed)	8 (5)
Family Size	2	12 (7.5)
	3	43 (27)
	4	**52 (32.7)**
	5 or more	**52 (32.7)**
Children B-5 in Family	None	1 (0.6)
	1	**75 (47.2)**
	2	59 (37.1)
	3 or more	24 (15.2)

**Note: Percentages are based on the number of persons responding to an item. n=159*

Table 10.3 captures information relative to socio-economic status, approximately two in five parents (42%) reported having graduated from high school or earned a GED certificate, and just under one-third (31%) had completed some college or had earned an AA or BA/BS degree. Approximately one-fourth of respondents (26%) reported being employed part-time or self-employed, while close to two-fifths (38%) reported being employed full-time. More than half (57%) reported incomes less than $35,000 and 47% reported having insurance either through Medicaid or Medicare.

Taken together, Tables 10.1, 10.2, and 10.3 provide a vivid picture of the vulnerability of the parents who access ECE programs and services in the USVI, with just over 60% being either uninsured or on public insurance, and having no higher than a high school education; over 50% are unemployed or employed only part-time; and the majority – almost 6 in 10 not being self-sufficient, given the size of the majority of households (three or more persons) and the annual household income – under $35,000, with 7 in 10 households headed by a single parent (single, never married or divorced).

Table 10.3

Socio-economic Characteristics of Parents/Guardians

CHARACTERISTIC	CATEGORY	NUMBER (PERCENT)*
Educational Attainment	Less than HS Diploma	33 (20.7)
	High School Diploma/GED Certificate	**67 (42.1)**
	CDA/Some college/AA	37 (23.2)
	BA/BS or higher	12 (7.5)
Employment Status	**Employed, full-time**	**60 (37.7)**
	Employed, part-time or self-employed	41 (25.7)
	Unemployed	44 (27.7)
	Other (retired or 'other')	14 (8.8)
Household Income	**Less than $35,000**	**89 (56.7)**
	Less than $50,000	11 (7.0)
	Less than $75,000	11 (7.0)
	$75,000 or greater	9 (5.7)
	Not sure	37 (23.6)
Type of Insurance	Private, through job	42 (27.1)
	Public (Medicaid or Medicare)	**73 (47.1)**
	Uninsured	21 (13.5)
	Other (self-insured or 'other')	19 (12.2)

Parents completed the survey *Quality of Care from a Parent's Point of View: A Questionnaire about Childcare* (Emlen, Koren, & Schultze, 2000). The findings to be shared in this section of the Needs Assessment focus on six* of the seven scales used to assess

distinct aspects of quality as well as one 15-item scale** to assess overall *Quality of Childcare* (Emlen, et al., pp. 184-185). The seven scales, number of items, and reported reliabilities are captured in Table 11. Further, as is captured in Table 11, reliabilities for the subscales – as measured by Cronbach's alpha – for the USVI parents/guardians who completed the survey are within the range of those reported in the literature, with the exceptions of the subscale, *Children feel happy, safe, and secure*, for which the reliability for the USVI parent sample was α = .70, compared to the reliability reported by Emlen, et al (2000) of α = .85.

Table 11

Subscale Reliabilities for Measuring the Quality of Childcare from a Parent's Point of View

Scale	No. of Items	Reliability*	Reliability (USVI sample)
Caregiver's warmth and interest in my child	6	.92	.90
Rich environment and activities	5	.91	.82
Caregiver's skill	3	.80	.76
Supportive parent-caregiver relationship	6	.84	.84
Child feels happy, safe, and secure	6	.85	.70
Risks to health, safety, and well-being	10	.85	.87
Composite Quality of Childcare Measure	14*	.91	.88

Table 12 captures the six items associated with the *Caregiver's warmth and interest in my child* scale and highlights key parent responses. Detailed responses for all scales reported in this Needs Assessment are captured in Appendix VI. Responses to the six questions for this scale show that parents who participated in the survey were very positive about the warmth and interest that their children's caregivers' demonstrated, with an overwhelming majority (91% - 94%) agreeing that caregivers treat their children with respect, take an interest in their children, and are warm and affectionate toward their children.

Table 12

'Always or Often' Responses to *Caregiver's Warmth and Interest in my Child* Statements

ITEM	ALWAYS OR OFTEN Number (Percent)
My caregiver is happy to see my child.	144 (92.4)
The caregiver is warm and affectionate toward my child.	142 (91.6)
My child is treated with respect.	146 (94.2)
The caregiver takes an interest in my child.	139 (90.8)
My child gets a lot of individual attention.	116 (76.4)
The caregiver seems happy and content.	134 (86.4)

While three of four parents felt that always or often "*there are lots of creative activities going on"* at the childcare locations where their children attend, between 82% and 92% of

parents responded 'always or often' to the other four items related to childcare facilities having a rich environment and a range of activities for their children (Table 13).

Table 13

'Always or Often' Responses to *Rich Environment and Activities* Statements

ITEM	ALWAYS OR OFTEN Number (Percent)
There are lots of creative activities going on.	115 (75.2)
It's an interesting place for my child.	132 (86.2)
There are plenty of toys, books, pictures, and music for my child.	141 (91.5)
In care, my child has many natural learning experiences.	129 (84.3)
The caregiver provides activities that are just right for my child.	126 (81.8)

Parents responded to three items related to caregivers' skills. While approximately 88% of parents felt that [their children's] caregivers 'always or often' *know a lot about children and their needs*, just under seven in ten parents (69%) responded that their children's caregivers *change activities in response to their children's needs* 'always or often'.

The overwhelming majority of parents (89%) shared that they 'always or often' feel welcomed by the caregiver (Table 14). Just over 8 in 10 felt that their children's caregivers are 'always or often' *supportive of them as parents* and are *supportive of how they want to raise their children*.

Table 14

'Always or Often' Responses to Statements Related to *Supportive Parent-caregiver Relationship*

ITEM	ALWAYS OR OFTEN Number (Percent)
My caregiver and I share information.	114 (75.5)
We've talked about how to deal with problems that might arise.	110 (72.4)
My caregiver is supportive of me as a parent.	126 (82.9)
My caregiver accepts the way I want to raise my child.	123 (81.5)
I'm free to drop in whenever I wish.	121 (79.6)
I feel welcomed by the caregiver.	135 (88.8)

Table 15 captures four of the six items on the *Child feels happy, safe, and secure* scale, one of the aspects of child-care quality (Emlen et al., 2000). The four items are all stated in the positive, with approximately 96% of parents of those responding that *My child feels safe and secure* 'always or often'. On average, 9 of 10 parents responded 'always or often' to the positive statements regarding their children feeling happy, safe, and secure with their caregivers or in the childcare facilities.

Table 15

'Always or Often' Responses to Statements Related to *Child feels happy, safe, and secure*

ITEM	ALWAYS OR OFTEN Number (Percent)
My child feels safe and secure.	147 (95.5)
My child has been happy in this arrangement.	141 (91.5)
My child feels accepted by the caregiver.	141 (92.2)
My child likes the caregiver.	123 (81.5)

For the two items stated in the negative, *My child has been irritable since being in this arrangement* and *My child feels isolated and alone in care*, two-thirds and more than three-fourths, respectively noted that their children 'never or rarely' experienced those negative feelings.

The next scale of note is the 10-item scale, *Risks to health, safety, and well-being*. Like the *Child feels happy, safe, and secure* scale, the *Risks to health, safety and well-being* scale comprises both positively – non-risk (3) and negatively (7) phrased items – items that would pose a risk to a child or to children. Table 16 captures the negatively stated items. Of the seven risk-related items, there were five items for which as few as 3% of parents and no more than 8% of parents felt that those risks were often or always present in the childcare facility. For two of the seven items, *too many children being cared for at the same time* and *the caregiver's need for additional help with the children*, 15% and 12% of parents, respectively felt that those conditions were either 'always or often' true in their children's care facility. Thus, most parents did not believe that the care facilities posed risks to their children's health, safety, or well-being.

Table 16

'Always or Often' Responses to *Risks to health, safety, and well-being* Statements

ITEM	ALWAYS OR OFTEN Number (Percent)
There are too many children being cared for at the same time.	23 (15.2)
The caregiver needs more help with the children.	18 (11.9)
The caregiver gets impatient with my child.	8 (5.3)
The children seem out of control.	6 (4.0)
The conditions are unsanitary.	8 (5.2)
The children watch too much TV.	5 (3.3)
I worry about bad things happening to my child in care.	12 (7.9)

The items included in the composite scale measuring *Quality of Childcare* are captured in Table 17 and, as can be noted, the items come from the scales previously presented. The responses captured in Table 17 show clearly that the overwhelming majority of parents who

responded to the parent survey feel that their children are receiving quality childcare in settings that are safe and secure, with caregivers that are competent, warm, and caring and take an interest in their children. Considering parents' responses to the subscales used to assess quality, as well as the composite scale, the findings suggest that families who access the ECE MDS feel that their children are receiving quality care in a safe environment, with qualified caregivers who demonstrate warmth and interest in their children.

Table 17

Composite Scale Measuring Quality of Childcare: 'Always or Often' Responses

ITEM	ALWAYS OR OFTEN Number (Percent)
My child feels safe and secure in care.	147 (95.5)
The caregiver is warm and affectionate toward my child.	142 (91.6)
It's a healthy place for my child.	131 (86.2)
My child is treated with respect.	146 (94.2)
My child is safe with this caregiver.	142 (92.8)
The children watch too much TV.	5 (3.3)
My child gets a lot of individual attention.	116 (76.4)
My caregiver and I share information.	114 (75.5)
My caregiver is open to new information and learning.	125 (80.6)
My caregiver shows she/he knows a lot about children and their needs.	135 (87.6)
The caregiver handles discipline matters easily without being harsh.*	
My child likes the caregiver.	123 (81.5)
There are a lot of creative activities going on.	115 (75.2)
It's an interesting place for my child	132 (86.2)
My caregiver is happy to see my child.	144 (92.4)

**Note: This item was not included in the version of the questionnaire used.*

75% *of parents gave a grade of* ***perfect*** *or* ***excellent*** *to the quality of care their child receives;* ***81%*** *noted that current care is 'just what my child needs' and* ***84%*** *indicated that if they had to do it over,* ***they would choose the same care.***

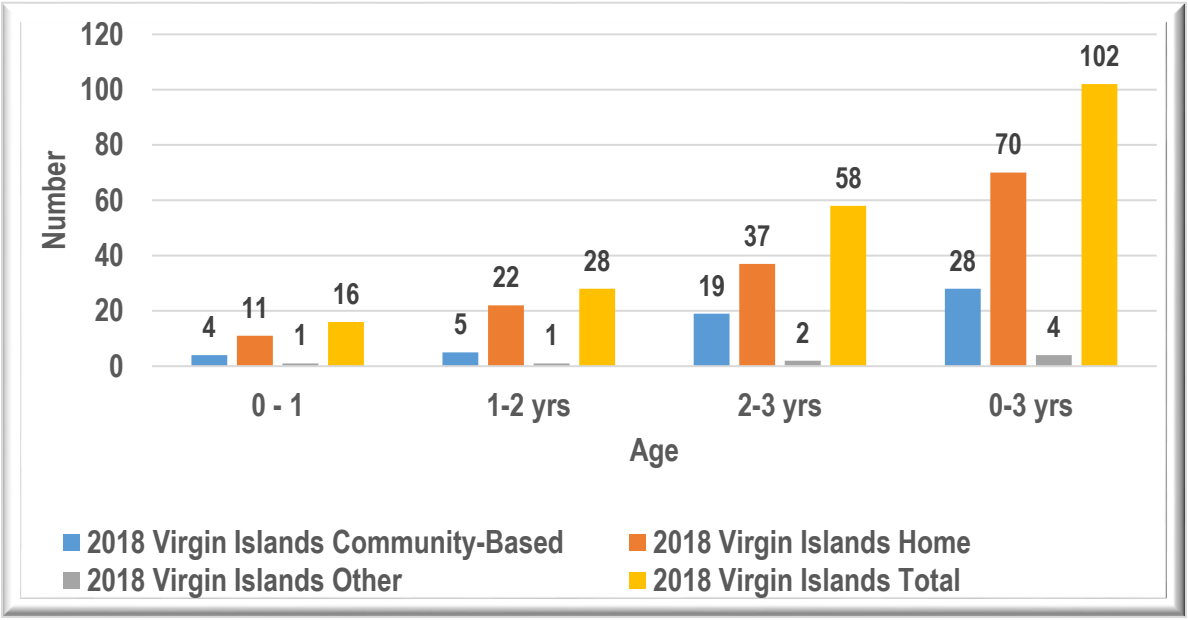
Programs and Services to Children with Special Needs – Birth through Five

Of importance in understanding and assessing needs for children within the USVI's ECE MDS is consideration of quality and availability of programs, services, and support for children with special needs – specifically, children who are eligible for services under Part C and Part B. This section of the Needs Assessment will provide a summary of data available to speak to this important group of vulnerable children in the Territory's ECE MDS by looking at children with special health care needs (CSHCN).

Children who have a physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount that requires prescription medication, more services than most children, special therapies, or which limits his or her ability to do things most children can do, must be provided for within an ECE system. The use of or need for specialized medical, educational, and social services associated with having a special health care need can have a significant impact on both families and service systems charged with meeting these needs. Therefore, understanding the extent and nature of special health care and educational needs among children is critical for the provision of services today and for planning to meet future demands (Federal Interagency Forum on Child and Family Statistics, 2009, pg. 70).

For eligible children birth to three years of age, the USVI provides direct Early Intervention Services (EIS) through the Infant and Toddlers Program (Part C) housed in the VIDOH. As reported in its FFY 2019 Part C Grant Application, EIS services provided to this population include appropriate evaluations/assessments to determine the scope, intensity, and duration of the services to be provided, the development of the requisite IFSP, and the convening of multidisciplinary meetings with parents and representatives from other key agencies, and convening transition meetings. Figure 22 captures the most recent child count data for eligible children served by the USVI Part C Program in FY2017-2018 as well as the settings in which services were provided.

Figure 22. **USVI Part C Program: Child Count by Service Setting – FY2017-2018**



According to data from the VIDE's State Office of Special Education (SOSE), during the period SY2014 – 2015 to SY2017 – 2018, the number of children, ages 3 – 5, with special needs and disabilities receiving services ranged from 98 to 126, territory-wide. An examination of the data by district reveals that except in SY2015 – 2016, when there was a slight year-on-year decline in the number of special needs children, there was a higher demand for special needs services in the St. Thomas/St. John district, than in St. Croix (Figure 23).

Figure 23. **USVI Child Count for Children Ages 3 – 5 with Special Needs/Disabilities: SY2014-2015 to SY2017-2018**

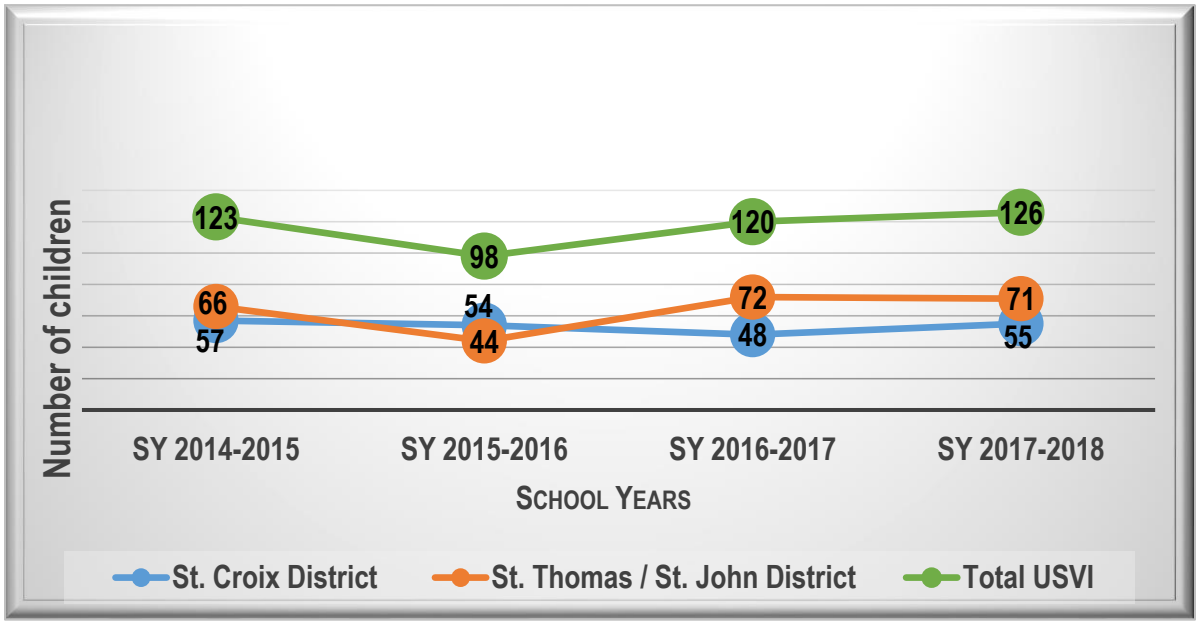
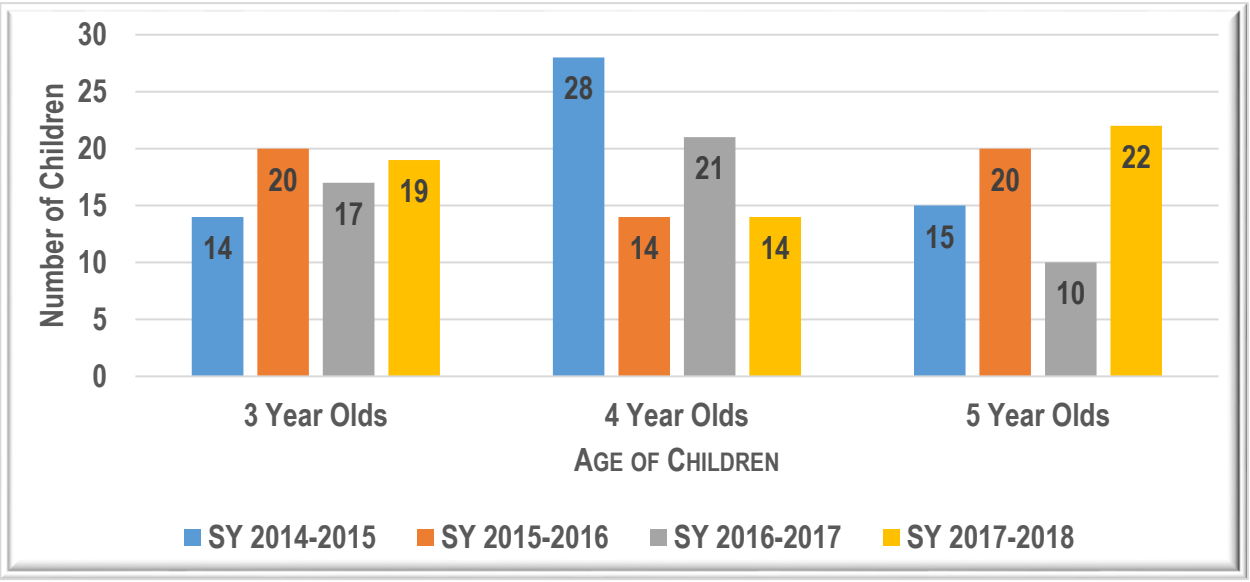


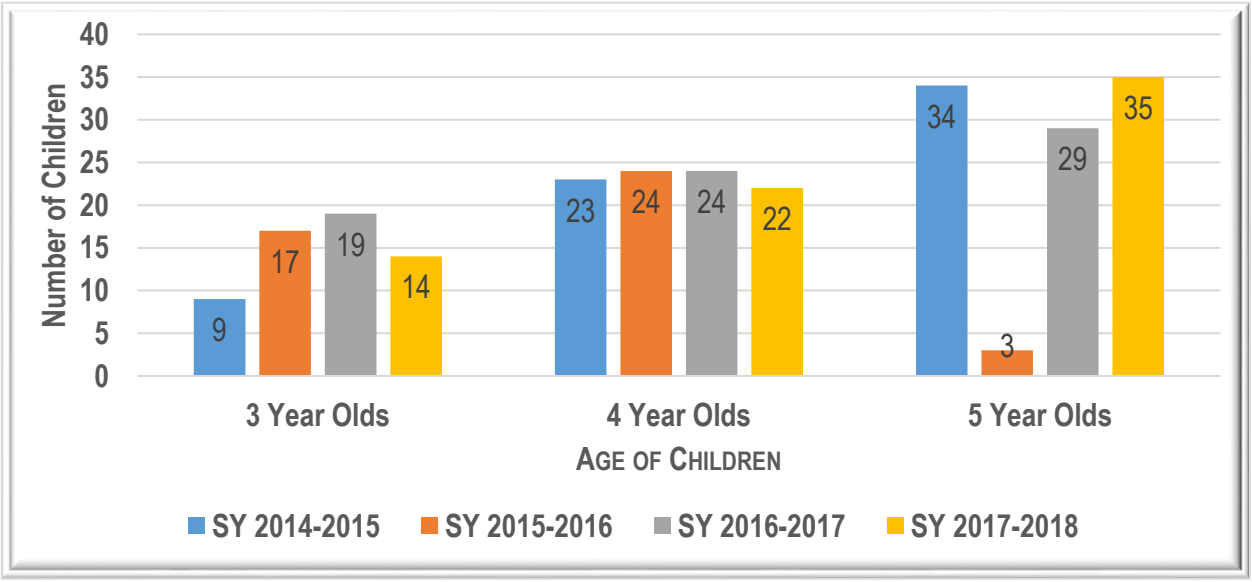
Figure 24.1 shows that, for the St. Croix District, four-year-old children, as a group, make up most of the children with special needs for the school years reviewed.

Figure 24.1. **St. Croix District Child Count Data: SY2014-2015 to SY2017-2018**



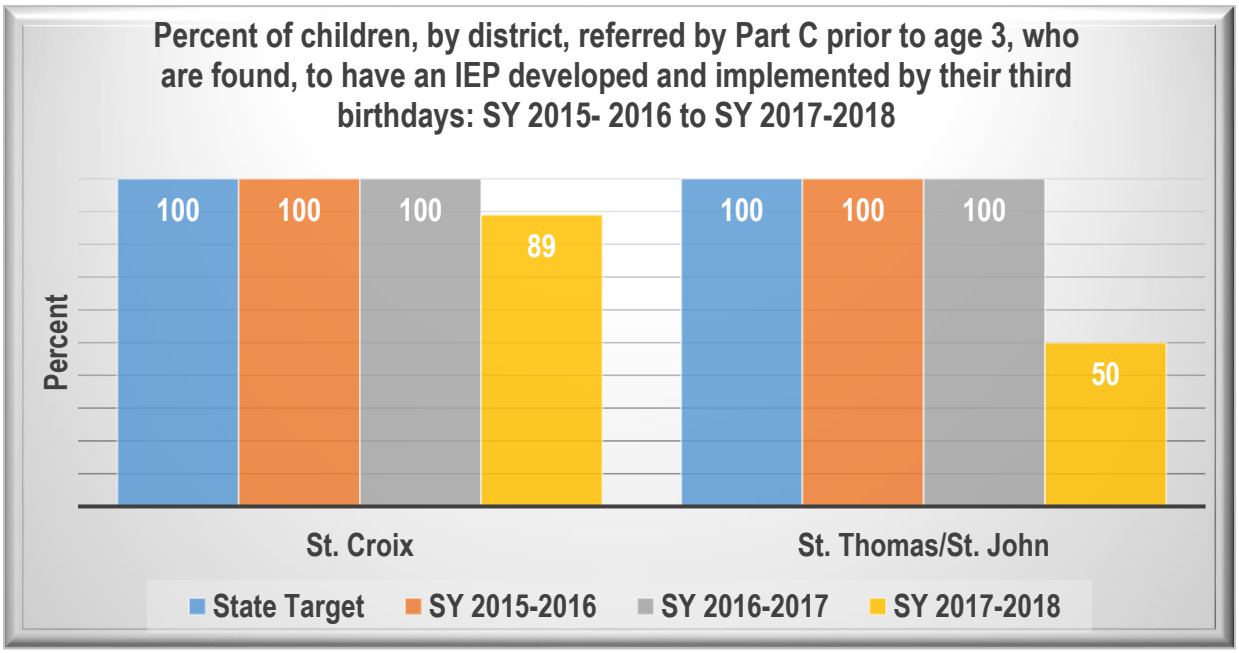
For the same period in the St. Thomas/St. John district five-year-olds formed the largest group of children with special needs and disabilities (Figure 24.2). Notably, in the St. Thomas/St. John district, except in SY2016 – 2017, five-year-olds outnumbered the three and four-year olds. Additionally, the number of children in the district increased year-on-year for all ages, except for five-year olds in SY2016 – 2017. This is probably indicative of late interventions for some children with special needs in the St. Thomas/St. John district.

Figure 24.2. **St. Thomas-St. John District Child Count Data: SY2014-2015 to SY2017-2018**



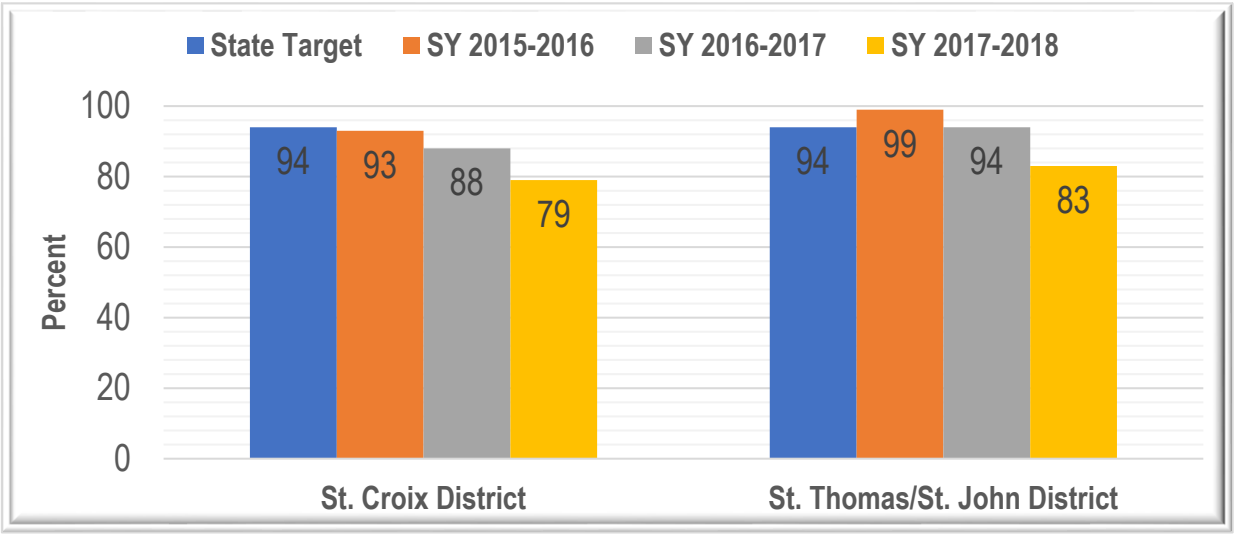
Data reported in the annual performance report for the OSEP in the Territory show that for SY2015 – 2016 and SY 2016 – 2017, all children who were referred to Part C prior to age 3, had an IEP developed and implemented by their third birthdays. However, that percentage declined in both districts in SY2017 – 2018 to 89% in St. Croix and only one-half (50%) of children with special needs had IEPs developed and implemented before their third birthdays in St. Thomas/St John in that school year that was adversely affected by the devastation caused by hurricanes Irma and Maria (Figure 25).

Figure 25. **IEPs Completed for Children Receiving Services through Part C: SY2015-16 to SY2017-18**



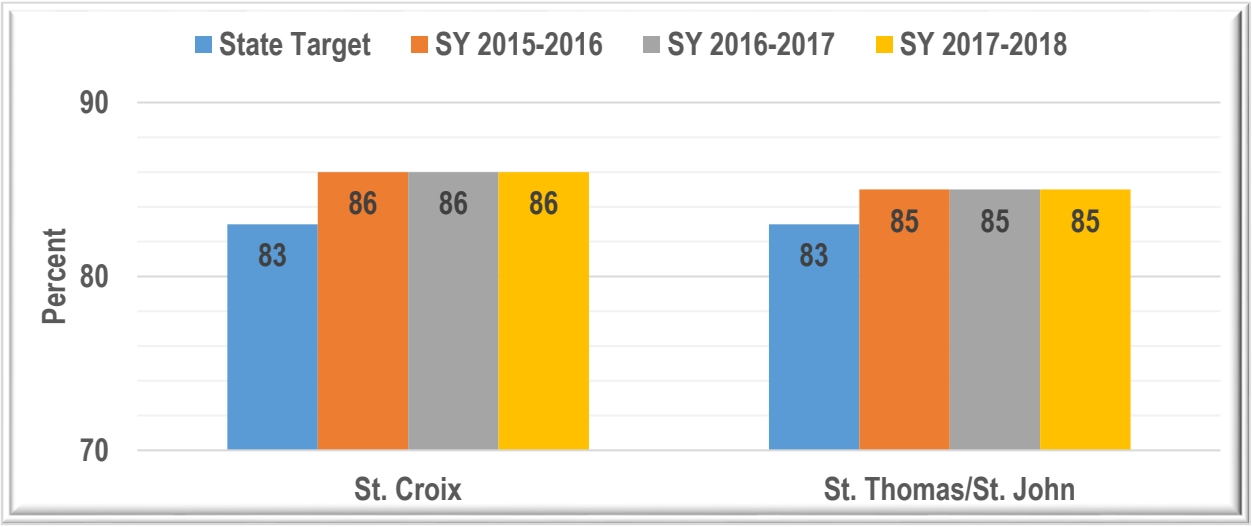
The Division of Special Education offers all related services (e.g. speech therapy, occupational therapy, physical therapy, vision services) and specialized instructional services (special education teacher) to all early childhood programs that have identified students with disabilities in Head Start and private pre-Kindergartens. Students not enrolled in childcare centers receive services at office locations or at a public-school location near to their homes.

Figure 26. **Children Ages 3-5, with IEPs, Attending and Receiving Special Education-Related Services in ECE Settings: SY2015-16 to SY2017-18**



The Territory sets a target for 94% of children aged 3 to 5 with IEPs attending regular ECE program and receiving most of the special education and related services in the regular ECE program. Figure 26 shows that in the district of St. Croix, for the period SY2015- 2016 to SY2017 – 2018, there was a failure to achieve the stated target. On the other hand, in the St. Thomas/St. John district the State Office of Special Education (SOSE) achieved its state target in two of the three school years. However, in both districts, the percent of parents with children receiving special education services who reported that schools facilitated parent involvement as a means of improving services and results with their children, consistently exceeded state target for the period under review (Figure 27).

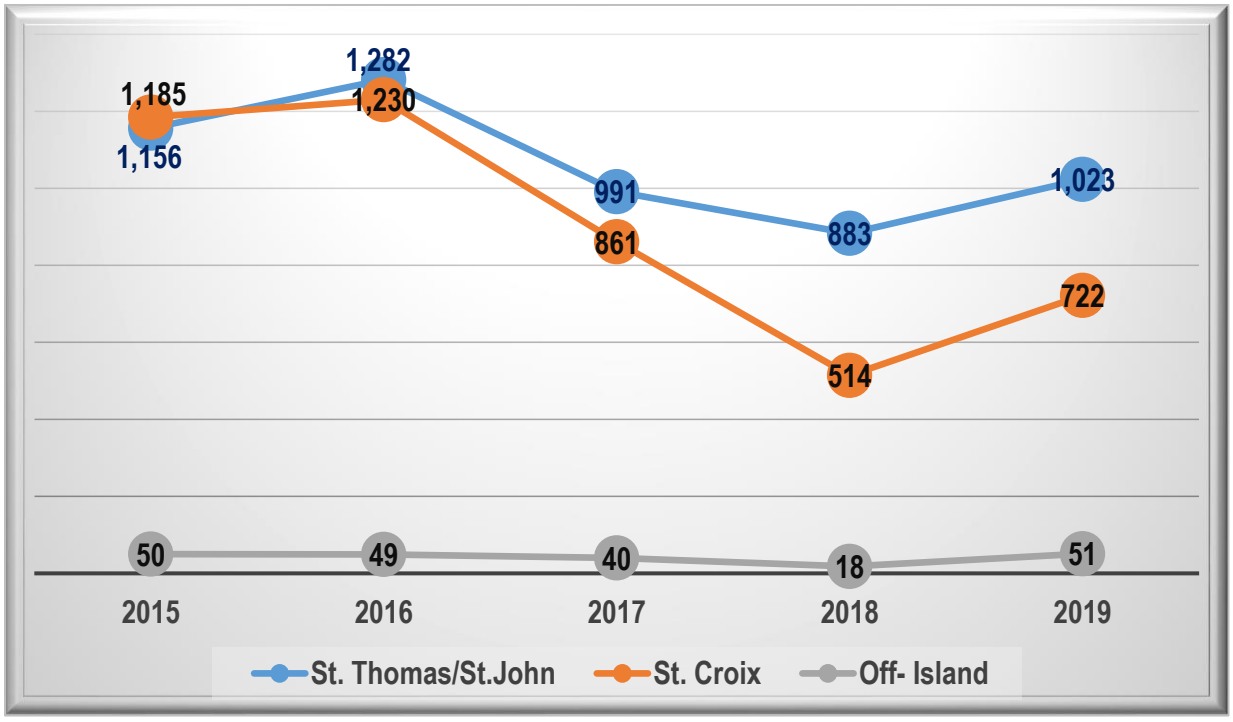
Figure 27. **Parents of Special Needs Children Reporting Facilitation of Parent Involvement to Improve Services and Outcomes for Children: SY2015-16 to SY2017-18**



There were nine items on the Parent Survey 'About your child's special needs'. This scale had acceptable reliability, with α=.78. However, a review of the actual survey responses showed fewer than 10% of respondents indicated that their child had a special need or related disability. This is an area where additional, focused data collection is needed to be able to determine the needs of families more accurately for B-5 children with special needs. Detailed responses to the nine items are included in Appendix VI.

In addition to services and supports provided to children with special needs by the Part C, Infant and Toddlers Program, housed in VIDOH, and Part B, the State Office of Special Education (SOSE), housed in the VIDE, the Medical Assistance Program (MAP), housed in VIDHS also provides support for B-5 children with special needs who need medical support whether those services are provided in the Territory or off island. Figure 28 provides a snapshot of the unduplicated number of B-5 children with special needs who received health/medical support through the MAP program over the past five fiscal years. The graph shows that for FY2018-2019, approximately 1800 special needs children were supported, with the majority being in the St. Thomas-St. John District and fewer than 5% needed to receive services outside of the Territory.

Figure 28. **Special Needs Children B – 5 Supported by MAP: FY2014-2015 to FY2018-2019**



Programs and Services for Dual Language Learners (DLLs) – Birth through Five

The USVI Head Start Program gives special attention to children who are DLLs, beginning with the intake and registration process (USVI DHS 2018-2019 HS Continuation Grant Application). Bilingual staff and interpreters are made available to support children, parents, and teachers at transition activities, child assessment discussions, parent orientations and parent conferences. Also, home visits are conducted in the language of preference for parents, whenever possible. The home languages most seen in the HS program are Spanish and French Creole, with the number of French Creole-speaking families entering the HS program increasing on the island of St. Thomas. In its HS Continuation Grant Application, the VIDHS acknowledged that the Program Assessment indicated a need to increase the number of bilingual teachers in HS classrooms. In the interim, to address translation needs, the HS program has partnered with the VIDE JOBS program to identify bilingual students who provide translation services to the HS program in support of DLL students and their families.

For the EHS program, during a key informant interview with the program director and the CEO of the umbrella organization for the EHS program, LSSVI, the EHS program director described supports provided for families that speak languages other than English. Specifically,

> *… we specifically identify, you know, whether they're English, Spanish, Creole, yeah, Arabic. And we identify those children as dual language learners. And then within the classroom, we ensure that there's a staff member, whether it's the lead teacher, the co-teacher, the floater teacher assistant, or a volunteer who speaks the same language of the child. For example, we have an increase in the Arabic population, Arabic speaking population, especially in the West Center. And as a result, we have two, we had a hired a co-teacher, who spoke the language and a volunteer. And that volunteer only has 25 more hours to go as …. So we'll do her interview, yes, and then she will be on staff as a teacher. We ensure that whatever the language is the language spoken at home, that there is somebody who speaks that language, and it's captured in our PIR report.* [KI, PAOS Head, LSSVI/EHS Director, August 2019]

In addition to the HS and EHS programs, key informant interviews with heads of key agencies providing direct or support services to B-5 children and their families – the two FQHCs in the Territory; VIDE, and VIDOH – note the use of electronic translation services as well as bilingual staff to ensure that appropriate and effective communication occurs with families so that information that needs to be communicated is done so clearly and accurately.

III.7. INDICATORS OF PROGRESS

In this section of the Needs Assessment, information will be provided on the approach that the U.S. Virgin Islands has taken to track progress with respect to the quality of Early Childhood Care and Education in the Territory. The section will also address opportunities to track progress in achieving the goals of the Territory's PDG B-5 planning grant as well as opportunities to track progress related to the ECE MDS Strategic Plan being developed as part of the Territory's PDG B-5 project.

Overview of USVI Quality Rating and Improvement System (QRIS) – Virgin Islands Steps to Quality (VIS2Q)

With respect to indicators of progress within the current Early Childhood Care and Education Mixed-delivery System (ECE MDS), the Office of Childcare and Regulatory Services (OCCRS), housed in VIDHS, developed the Territory's Quality Rating and Improvement System (QRIS) to assess ECE programs in the Territory. Quality rating and improvement systems are designed to increase the likelihood that childcare and education arrangements meet developmental needs of children and the needs of parents. The system, V.I. Steps to Quality (VIS2Q) is a five-level/step system developed for center-based programs serving infants, toddlers, and preschoolers. Level 1 would be the first level and would signal that a program had met licensing requirements for ECE programs. Level 5 would represent the highest level of quality. VIS2Q standards were established to guide continuous quality improvement efforts in four (4) areas: (1) professional development and staff qualifications; (2) teaching and learning environments; (3) facilities, operations, policies, and leadership; and (4) family and community engagement. These four areas represent the four standards of the Territory's QRIS, VIS2Q. Each standard is further defined by several criteria, and each criterion has multiple indicators (approximately 326 in total) that describe what quality looks like at each Level/Step of the VIS2Q (Table 18.1)

Additionally, each of the four standards is further defined by criteria used to assess components of the standards. There are also multiple indicators of quality that further define each criterion. Tables 18.1 through 18.4 capture information on the standards, related criteria, and note the number of indicators associated with each criterion. Funding was received from OPRE, ACF, DHHS through Grant No. 90YE0152 to develop a Childcare Research Partnership (CCRP). According to Jaeger, Mills, and Braithwaite-Hall (2017), one of the

objectives of the CCRP grant was to collect data "… to inform policies and programs that seek to improve the quality of early care and education settings, and to begin to develop an infrastructure to conduct early childhood research in the Territory (p.1). Since the Territory had recently embarked on piloting its Quality Rating and Improvement System (QRIS), VI Steps to Quality (VIS2Q), as a pathway to improving quality in early childhood care and education in the Territory, the CCRP provided an ideal opportunity to assess the elements of the Territory's QRIS.

Table 18.1

USVI QRIS: V.I. Steps to Quality (VIS2Q) for ECE Programs – Standard I

Standard I	Criteria	No. of Indicators
Professional Development and Staff Qualifications	1.1.a. Director Qualifications	7
	1.1.b. Teacher Qualifications	7
	1.1.c. Assistant Teacher Qualifications	8
	1.2.a. Director Professional Development	18
	1.2.b. Teaching Staff Professional Development	25
	1.3.a. CQI: Assess Needs	8
	1.3.b. Plan Improvements	5
	1.3.c. Evaluate Progress	4

Of note is that though information was garnered from the research done on the piloting of the Territory's QRIS, VIS2Q, specific data were not available on the actual indicators that are aligned to the various criteria. Thus, as a strategic plan is developed to strengthen the existing ECE MDS, to expand access for vulnerable children and families, there also needs to be a focus on strengthening and fully implementing the Territory's VIS2Q.

Table 18.2

USVI QRIS: V.I. Steps to Quality (VIS2Q) for ECE Programs – Standard II

Standard II	Criteria	No. of Indicators
Teaching and Learning Environments	2.1. Planning and Curriculum	11
	2.2. Child Information, Screening and Assessments	12
	2.3.a. Classroom Learning Environments	6
	2.3.b. Promoting Positive Interactions	10
	2.3.c. Activities to Promote Physical Health	9
	2.3.d. Language and Literacy Activities – Preschool Classes	23
	2.3.e. Language and Literacy Activities – Infant/Toddler	14
	2.3.f. Language and Literacy Activities – Dual Language Learners	26
	2.4. Learning Supports for Children with Special Needs	8
	2.5. Continuity in Learning Environments	8
	2.6. Ratio and Group Sizes	2
	2.7.a. CQI: Assess Needs	7
	2.7.b. Plan Improvements	4
	2.7.c. Evaluate Progress	3

Table 18.3

USVI QRIS: V.I. Steps to Quality (VIS2Q) for ECE Programs – Standard III

Standard III	Criteria	No. of Indicators
Facilities, Operations, Policies, and Leadership	3.1. Program Operations	8
	3.2. Staff Policies	13
	3.3. Family Policies	8
	3.4. Support for Planning	7
	3.5. Facility Leadership	5
	3.6.a. CQI: Assess Needs	8
	3.6.b. Plan Improvements	6
	3.6.c. Evaluate Progress	6

Table 18.4

USVI QRIS: V.I. Steps to Quality (VIS2Q) for ECE Programs – Standard IV

Standard IV	Criteria	No. of Indicators
Family and Community Engagement	4.1. Routine Communications with Families	8
	4.2. Family Involvement and Support	8
	4.3. Promoting Families as First Teachers	5
	4.4. Program – Family – Community Linkages	5
	4.5.a. CQI: Assess Needs	5
	4.5.b. Plan Improvements	4
	4.5.c. Evaluate Progress	5

The Territory's VIS2Q was piloted over a three-year period, July 2013 through 2016 with a total of 67 licensed programs serving preschool children participating – 31 from the St. Croix District, including nine Head Start facilities and 36 from the St. Thomas-St. John District, including eight Head Start facilities. Through federal funding the researchers conducted a study, the VI QRIS Virtual Pilot Project, to determine the validity of the VIS2Q "… by assessing the measurement strategies and psychometric properties of measures used to assess quality, and how these related to child outcomes (p. 12)" (Jaeger, et. al, 2017).

Due to various challenges, the study did not include or review child outcomes. However, based on observation data collected using the Early Childhood Environment Rating Scale (ECER-S), the Classroom Assessment Scoring System (CLASS), the QRIS Classroom Observation Addendum, and the Language and Literacy Practices Checklist, the study found substantial variability in quality at the classroom level. Though the latter two observation instruments were developed specifically for the study, the first two, the ECER-S and the CLASS, have good reliability and in the pilot study also were found to have acceptable to high reliability.

A major finding of the CCRP's study on the piloting of the Territory's QRIS – the VIS2Q – was that the ordering of the indicators need to be revisited, as some programs could not meet or demonstrate achievement of indicators at a lower step/level, but performed well or met indicators that were at a higher step/level. This led the researchers to conclude that there is a need to revisit the ordering of the indicators associated with each criterion in support of the four overarching standards of the Territory's QRIS, VIS2Q. Further, due to the number of indicators across the VIS2Q, the researchers noted that there would be a high cost to validate the various indicators, suggesting that for the Territory's QRIS to be viable, some of the initial indicators may need to be replaced and/or dropped.

Strengths and Weaknesses of VIS2Q Indicators

Based on the study completed on the piloting of the Territory's VIS2Q, one strength of the quality assessment system is the inclusion and use of psychometrically sound instruments for data collection. However, a weakness noted was the vast number of indicators and the ordering of the indicators on the 5-step/level of the quality continuum.

Capacity of VIS2Q Indicators to describe current conditions experienced by vulnerable, underserved and rural populations

Although not directly addressed in the study, the VIS2Q, as described, would allow for the documentation of conditions experienced by vulnerable and underserved populations, particularly because of the inclusion of classroom observations as an integral component of the system,. With respect to "rural" populations, the study that examined the VIS2Q did not focus specifically on vulnerable underserved and rural populations. Therefore, this is another area for further exploration as work continues to refine the Territory's VIS2Q.

Current opportunities for the USVI to develop additional measurable indicators to track progress in achieving PDG B-5 and USVI ECE Strategic Plan Goals

Based on a review of the findings from the VI QRIS pilot – the VIS2Q, indicators to guide continuous quality improvement were developed for center-based programs serving infants, toddlers, and preschoolers. Currently, OCCRS is in the process of reviewing and revising the Territory's QRIS, VIS2Q, for Early Care and Education Programs held in other settings.

Student Assessment as an Indicator of Progress toward School Readiness

In the current ECE mixed-delivery system in the USVI, one key indicator of progress is children's readiness for kindergarten. Within this context children's readiness is measured using a range of tools. Within the HS/EHS environment, student progress is assessed through CAP-60 (EHS) and COR (HS). At the kindergarten level, within the public K-12 educational system (VIDE), assessment modalities include the Learning Accomplishment Profile, 3rd Edition (herein after **LAP-3**). In addition to the LAP-3, VIDE utilizes **i-Ready** to determine students' academic skills in mathematics and reading. An interactive, online learning program, i-Ready is designed to provide individualized instruction based on a child's unique needs. Additionally, VIDE began using **ACCESS 2.0** in SY2015-2016 to assess ESL students from kindergarten through 12th grades. VIDE began using ACCESS 2.0 when it joined the World-Class Instructional Design and Assessment (WIDA) Consortium. The WIDA Consortium is housed within the Wisconsin Center for Education Research at the University of Wisconsin-Madison. These assessment tools have been documented in the literature to have acceptable psychometric properties, so can be viewed as being representative of viable indicators of progress with respect to student outcomes.

What follows is a snapshot of data available on the performance of children ages B-5 on the LAP-3, the instrument used to assess readiness of children transitioning to kindergarten, within the public K-12 educational system, from ECE programs – whether public (Head Start or Granny Preschool) or private (generally day care centers or preschools).

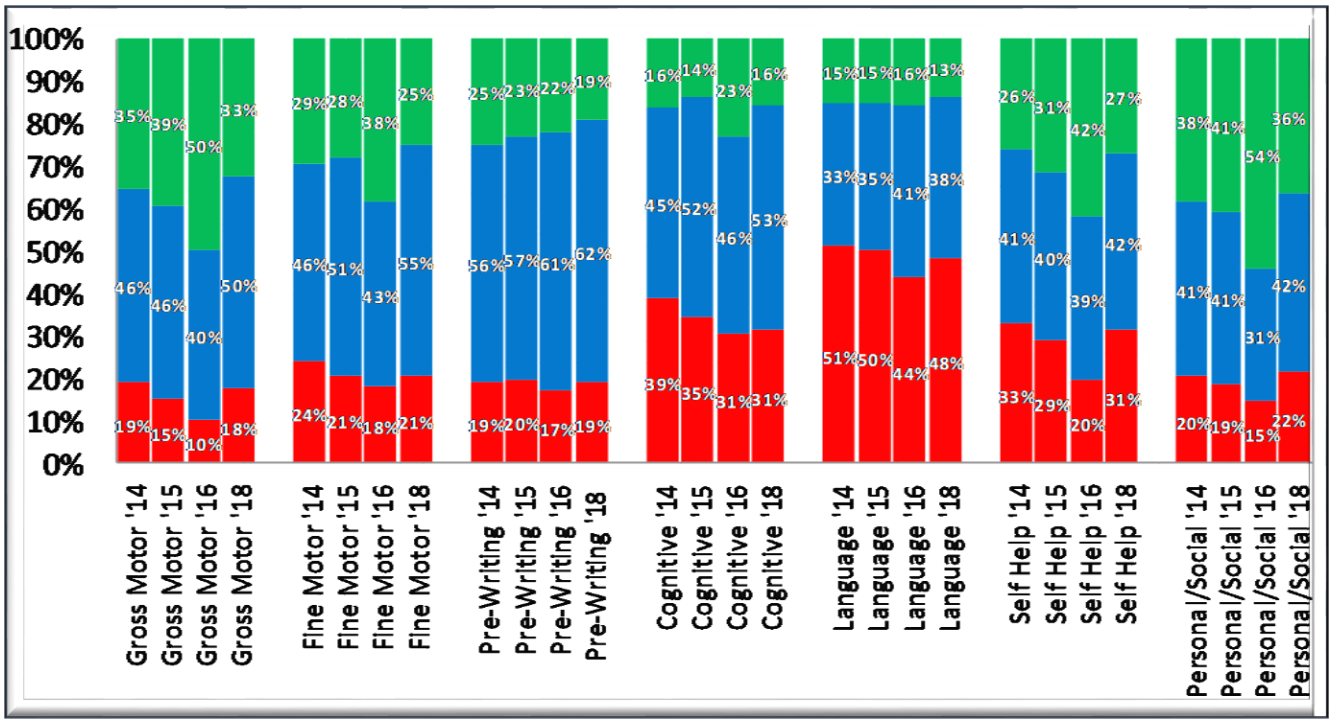
The Learning Accomplishment Profile, 3rd Edition (LAP-3)

The **LAP-3** is used by the Virgin Islands Department of Education (VIDE) to assess individual skill development of young children entering kindergarten. Assessment usually occurs in the spring prior to students' fall kindergarten enrollment. The LAP-3 is a criterion-referenced assessment appropriate for children functioning in the 36 - 72-month (3 – 6 year) age range. Children are assessed in seven skill-development domains: gross motor – GM (physical); fine motor – FM (physical); pre-writing – PW; cognitive – CG; language – LG; self-help – SH; and personal/social – (PS). Head Start and pre-K students are required to complete the LAP-3 assessment. During their kindergarten year, VIDE also assesses kindergarten student three times – once at the beginning of the school year; at the mid-point of the school year, and towards the end of the school year.

Figure 29, below, captures information on kindergarten children assessed using the LAP-3 during the fall of SY2014-2015; SY2015-2016; SY2016-2017, and SY2018-2019. Because of the significant disruptions caused by Hurricanes Irma and Maria in September 2017, testing did not occur in the fall of SY2017-2018. What is noteworthy as one peruses Figure 29 is that for *all school years included,* students' skill development were six months to a year below developmental age expectations for the group (LAP-3 definition of "below age" – being either considerably or moderately below age expectation) in the areas of *cognitive* and *language skill development*, with between 44% and 51% of kindergarteners being *below expected age levels in language skill development* and between 31% and 39% of kindergarteners being *below expected age level development for cognitive skills*.

Conversely, the largest proportion of kindergarten students demonstrating skill development above age expectations (6 – 12 months above developmental expectations, or moderately or considerably above expectations in skill development) can be observed in the areas of *gross motor* (33 – 60%) and *personal/social developmental skills* (36 – 54%).

Figure 29. **LAP-3 Performance for USVI Students in Public Kindergarten Classrooms – SY2014 – SY2018***



*Notes: 1) No data were collected during SY2016-2017 due to passage of Hurricanes Irma and Maria.

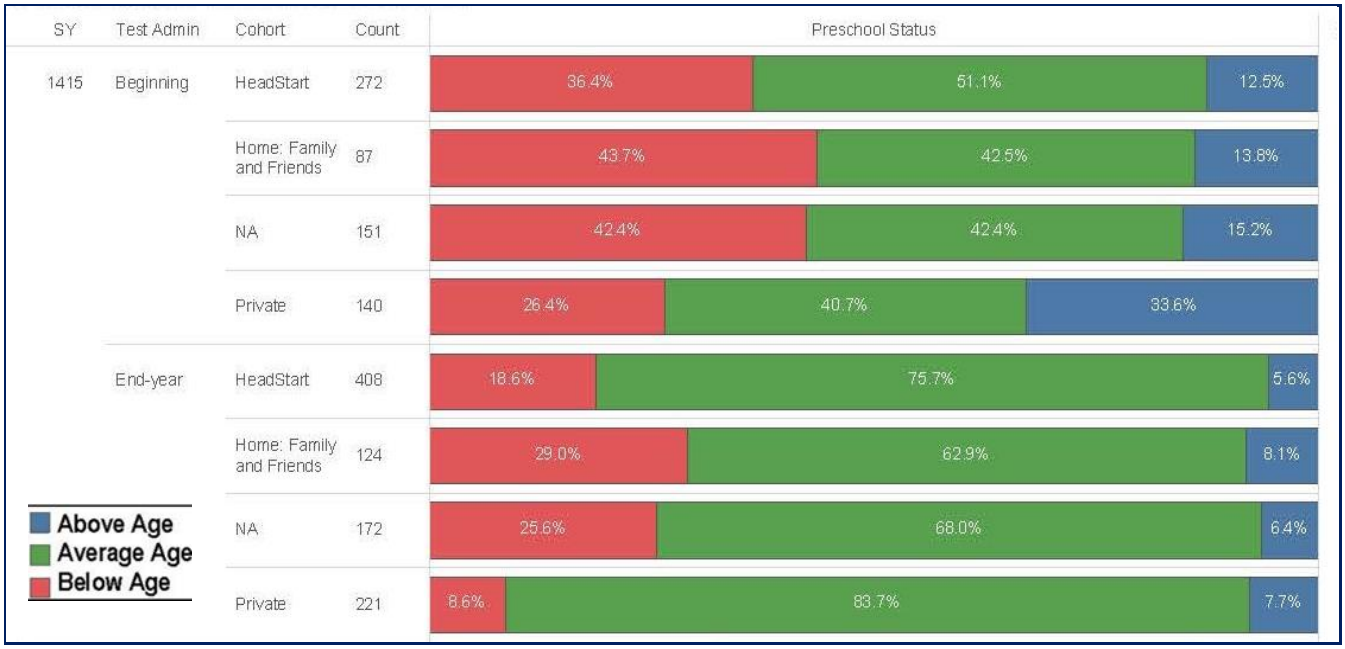
2) Legend: **Green = Above Age**; Blue = Average Age; **Red = Below Age**

For the four school years in question, the proportion of kindergarten students who tested below developmental age expectations were lowest for gross motor, fine motor, pre-

writing, and personal/social developmental skills, with the highest percentage below average at 24% (fine motor, SY2014-2015) and the lowest at 10% (gross motor, SY2016-2017).

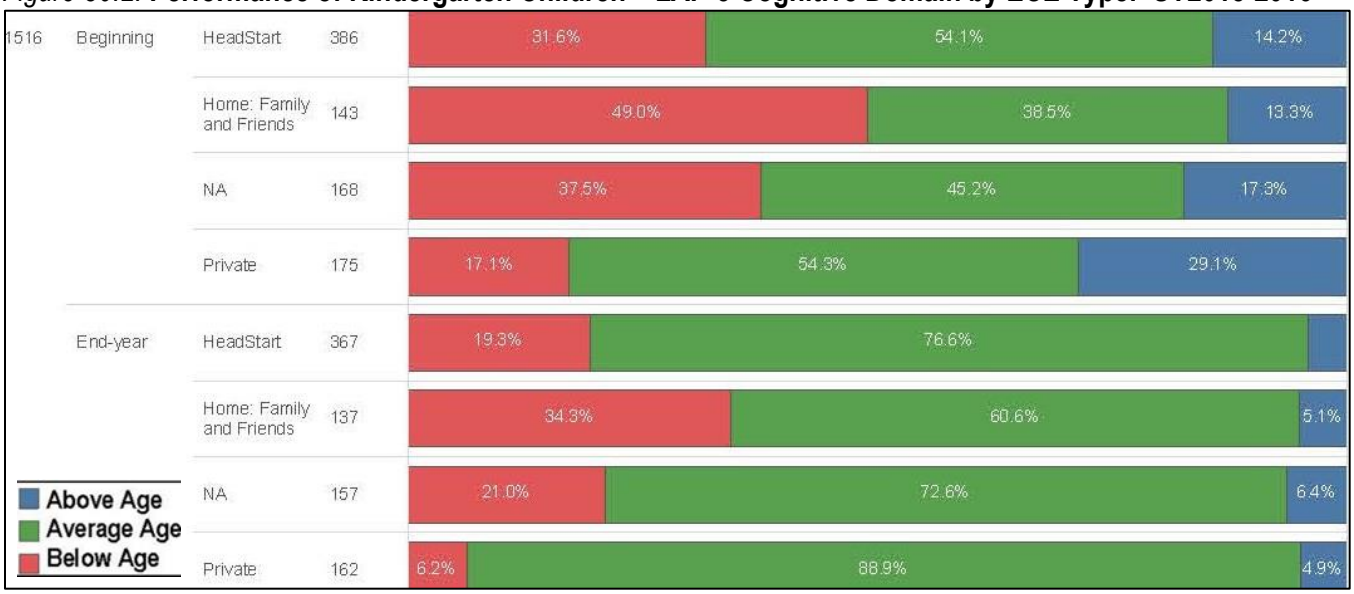
Figures 30.1 and 30.2 provide assessment information on the cognitive domain for public school kindergartners for SY2014-2015 and SY2015-2016. Kindergarten students most likely to perform below developmental age in the cognitive domain at the beginning of the school year were those whose early learning experiences were with family, friends, or neighbors (FFNs). Of note, however, is that for students whose ECE foundation was Head Start, between 32% and 36% performed below developmental age at the beginning of the school years examined.

Figure 30.1. **Performance of Kindergarten Children – LAP-3 Cognitive Domain by ECE Type: SY2014-2015**



A perusal of both Figures 30.1 and 30.2 show gains by all students in terms of the smaller proportions performing below developmental age expectations at the end the school year, with the highest gains from below developmental age occurring with students whose ECE foundation was in a private center/preschool. Of some concern is that for all groups, no matter the ECE foundation, there were losses in the proportion of students who performed above developmental age expectations at the end of kindergarten in the cognitive domain. Cognitive domain results for other school years are included in Appendix VII.

Figure 30.2. **Performance of Kindergarten Children – LAP-3 Cognitive Domain by ECE Type: SY2015-2016**



Figures 31.1 and 31.2 provide a snapshot of kindergarten children's performance on the Language Domain of the LAP-3 for SY2014-2015 and 2015-2016, respectively. As with Figures 29a and 29b, performance is presented by ECE foundation. For SY2014-2015, on average, over 40% of children performed below developmental age expectation in the language domain, with the largest proportion of children performing below developmental age expectation being children whose ECE foundation was an FFN experience. This is contrasted with the lowest proportion of children below developmental age expectation being from a private ECE setting.

Figure 31.1. **Performance of Kindergarten Children – LAP-3 Language Domain by ECE Type: SY2014-2015**

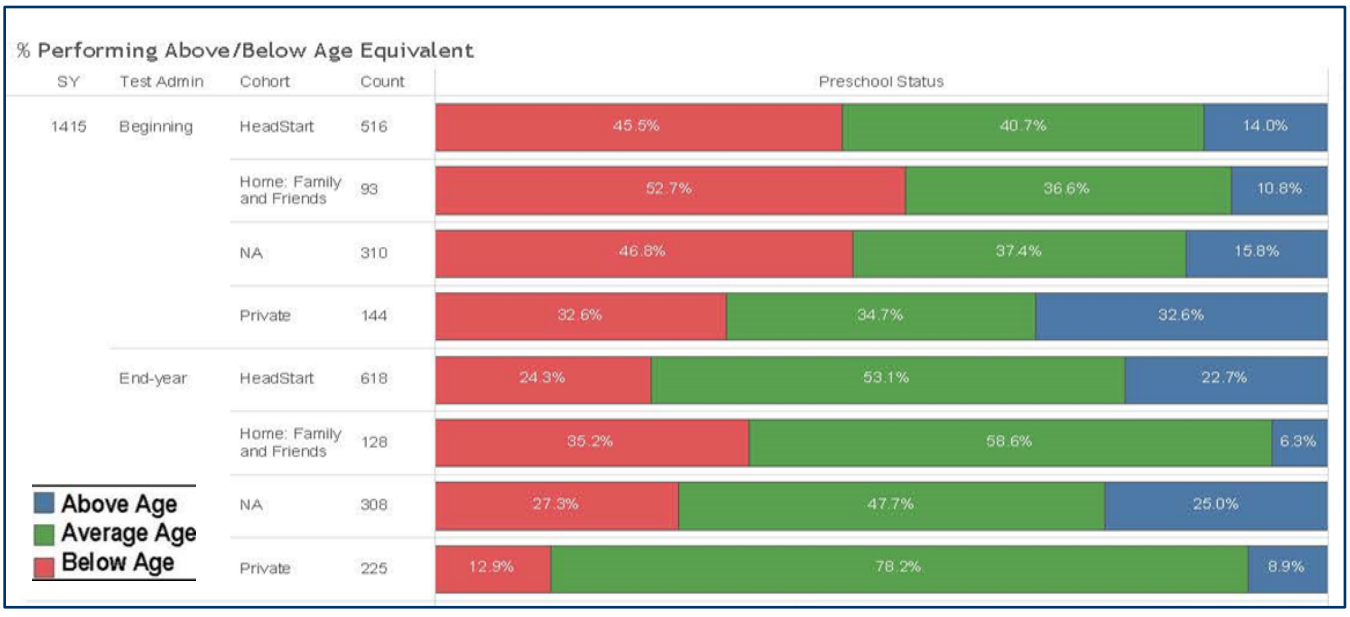


Figure 31.2. **Performance of kindergarten children – LAP-3 Language Domain by ECE Type: SY2015-2016**

Of note is that in the language domain, a larger proportion of children, regardless of their ECE foundation, performed below developmental age expectation on the language domain of the LAP-3 than on the cognitive domain, with more than 50% of children receiving ECE care from FFN environments performing below developmental age expectation.

It is also worth noting, as observed with results for the Cognitive Domain, while a third of the children from private ECE settings performed above developmental age expectations at the beginning of kindergarten, by the end of kindergarten, performance on the LAP-3 Language Domain was above developmental age expectation for fewer than 10% of the children. This pattern, which essentially shows a regression in performance merits further examination and possible action with respect to professional development and policy development. Additionally, by the end of kindergarten, for children whose ECE foundation was in an FFN environment, just over one-third still performed below developmental age on the LAP-3 at the end of kindergarten.

As can be observed from Figure 30.2, deficits in the language domain on the LAP-3 were even greater for kindergarteners in SY2015-2016 than during the previous school year. While two in five kindergarteners whose ECE foundation was HS performed below developmental age expectation, this was also the level of performance for one-third of children who had a private ECE foundation, while below developmental age performance is observed for seven in 10 children who received ECE care in an FFN setting. Deficits remained at the end of kindergarten, again with above developmental age performance lower for all groups.

In addition to differences in school readiness based on ECE care setting, LAP-3 data also show differences based on district, with kindergarten students from the St. Croix District consistently outperforming kindergarten students from the St. Thomas-St. John District, indicating that children entering the public K-12 system, those in the St. Croix District are more likely to be ready for the transition to kindergarten than are their peers in the St. Thomas-St. John District (Figures 32.1; 32.2). LAP-3 results by district for additional school years are available in Appendix VII.

Figure 32.1. **Performance of Kindergarten Children who attended HS on the LAP-3 Cognitive Domain by District: SY2018-2019**

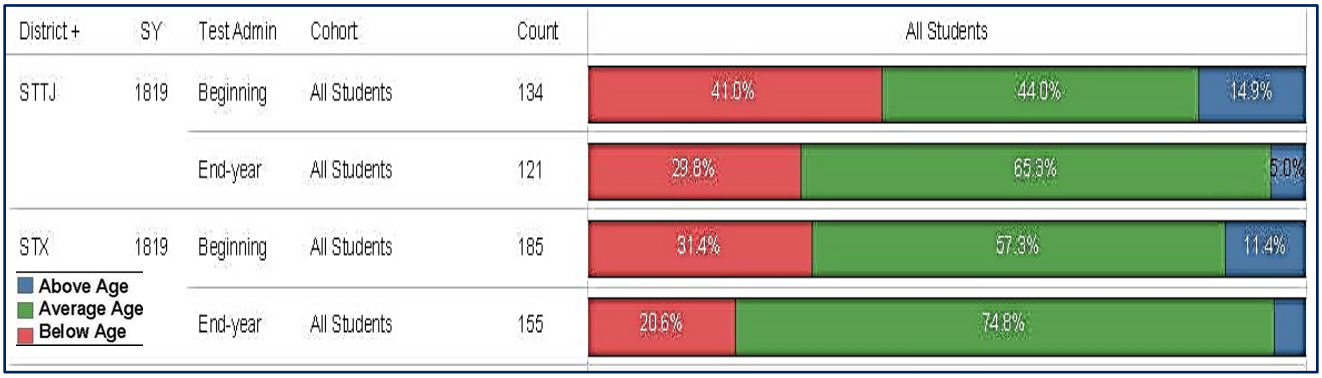
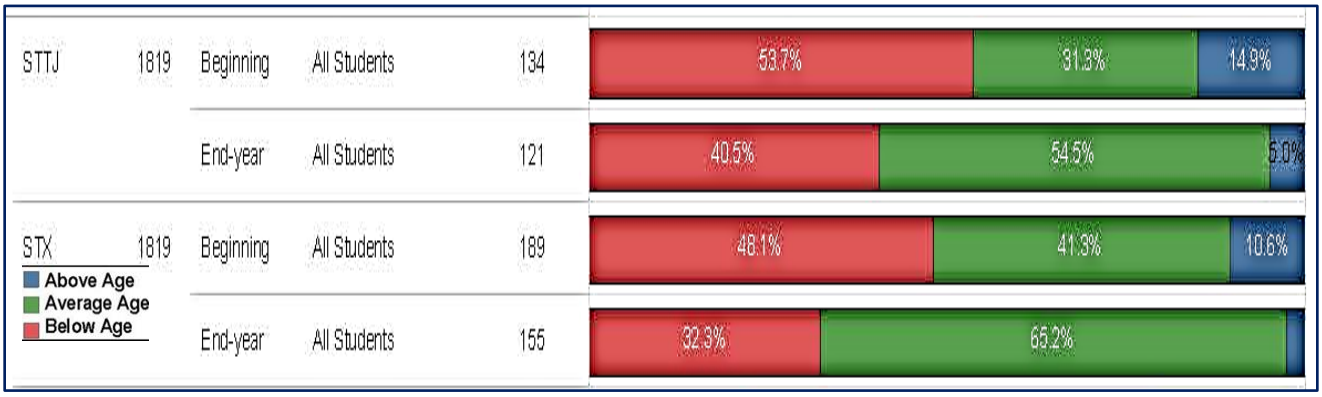


Figure 32.2. **Performance of Kindergarten Children who attended HS on the LAP-3 Language Domain by District: SY2018-2019**



Other Assessments

Head Start/EHS

Both the HS and EHS Programs in the Territory use the COR to assess children's progress through the program. Though specific data are not available for EHS children, during a key informant interview, the EHS Program director noted that, as with HS, data are collected and documented by EHS teachers three times during the school year.

Specifically for HS, as can be observed from Figures 33.1 – 33.3, COR results in the areas of language and literacy and mathematics and science for three consecutive school years (SY2017 – SY2019) for HS children align with LAP-3 cognitive and language and literacy results, plus district comparison, again to mirror LAP-3 information, both in terms of performance based on ECE foundation as well as district of residence. As with the LAP-3, HS children's performance in the areas of language and literacy (aligns with LAP-3 Language Domain) and science and mathematics (aligns with LAP-3 Cognitive Domain) were the two domains in which HS children performed poorest over three testing periods – beginning, mid, and ending of final HS year. Also noteworthy is that HS children in the St. Croix District consistently outperformed HS children in the St. Thomas-St. John District. This phenomenon is worthy of further exploration, given that all the economic data show that poverty is higher in the St. Croix District than in the St. Thomas-St. John District. Detailed performance information for HS children on all domains over the three school years reviewed is included in Appendix VIII.

Figure 33.1. **HS Students' Performance on COR Language and Literacy and Mathematics and Science Domains – Territory and Each District: SY2016-2017**

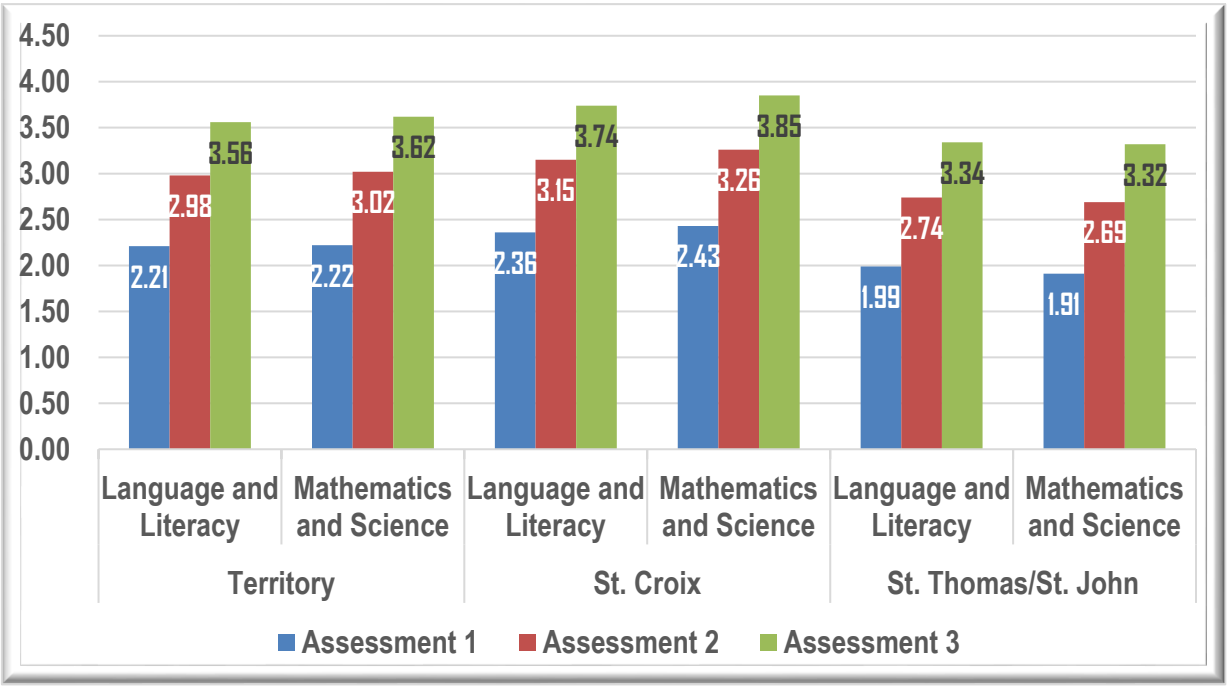


Figure 33.2. **HS students' performance on COR Language and Literacy and Mathematics and Science Domains – Territory and Each District: SY2017-2018**

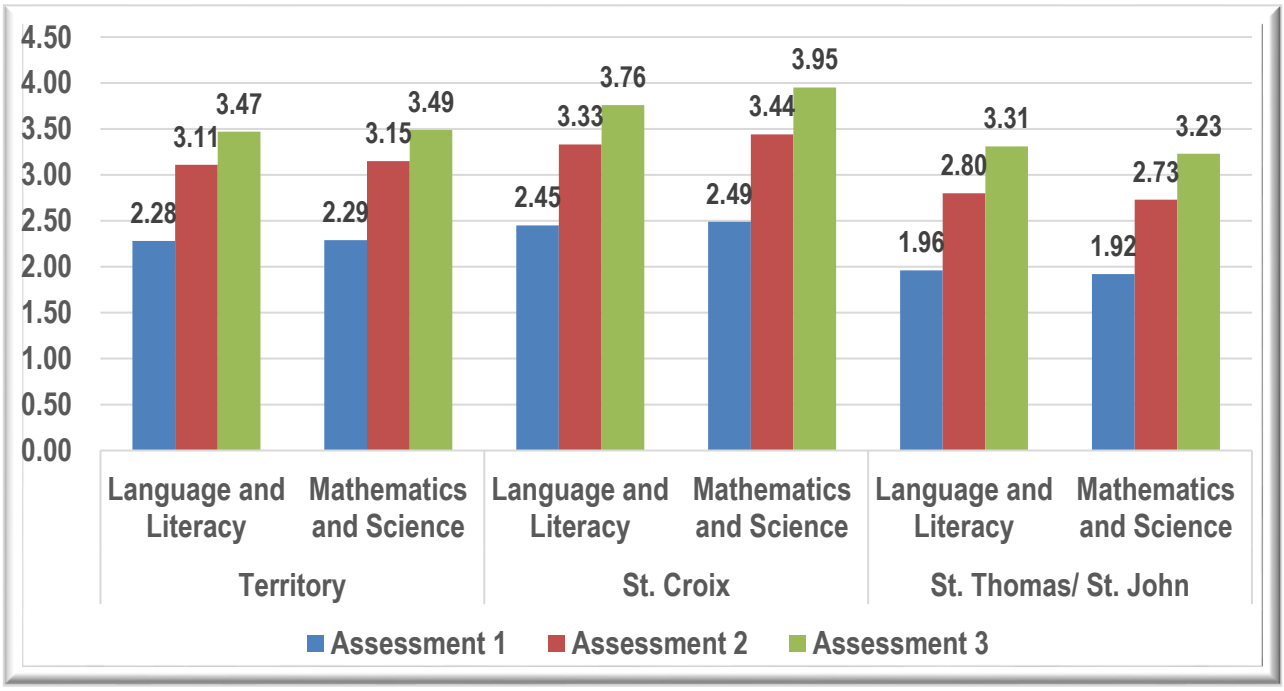
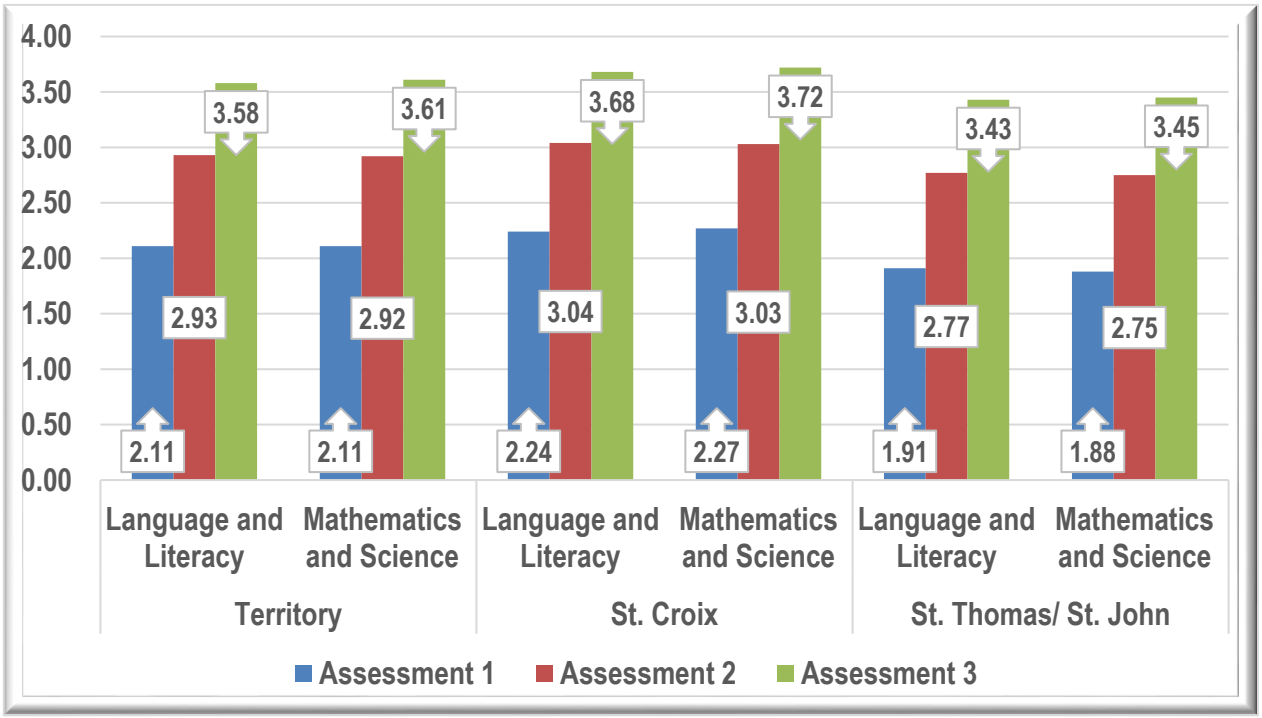


Figure 33.3. **HS students' performance on COR Language and Literacy and Mathematics and Science Domains – Territory and Each District: SY2018-2019**



Private and Parochial Preschools, Daycare Centers, FFNs

Mirroring the lack of a repository of information on curriculums utilized by private and parochial preschools and day care centers, there is no known repository of student assessment data for these entities. Though licensed and subsidized by the Office of Childcare and Regulatory Services (OCCRS), private entities within the Territory's ECE MDS are not required to capture and report to OCCRS assessment data or provide data reports that mirror any aspect of reporting requirements for HS/EHS programs. However, LAP-3 kindergarten assessment performance reported in Figures 30.1, 30.2, 31.1, and 31.2 serve as proxies for school readiness for children whose ECE foundation was a non-HS setting.

The data in Figures 30.1, 30.2, 31.1, and 31.2 show consistently, that, on average, in the cognitive and language and literacy domains, children whose ECE foundation is private childcare centers and preschools performed better on the LAP-3 than those whose ECE foundation was the Head Start program. Conversely, as a group, children whose early care was provided through the FFN network, on average, performed more poorly on the LAP-3 than either children transitioning from private ECE settings or those transitioning to Kindergarten from Head Start. These data provide an opportunity to strategically address this gap during the Territory's development of its ECE MDS strategic plan.

Specific data were not provided regarding indicators of progress for bilingual or special needs children, B-5. As previously reported, VIDE has begun capturing data through WIDA. However, this affiliation is recent and data specific to DLL kindergarten students were not available. As the Territory refines its QRIS, VIS2Q, there will be an opportunity to incorporate indicators related to progress for children B-5 who are DLLs and/or who have special needs that require the extension of an IFSP, the development of an IEP, or even the development of a 504 plan for children who transition to Kindergarten.

III.8. Transition Supports

This section of the Needs Assessment focuses on describing the transition supports and gaps that exist in the Territory's ECE MDS and how those transition supports and gaps affect how children B-5, move between early childhood care and education programs and kinder school entry. To do so, the types of transitions that occur within the Territory's ECE MDS are delineated, followed by more detailed information regarding existing supports and gaps with each type of transition. Attention is given to how information regarding each type of transition is communicated to parents/families and other key stakeholders; what specific supports are in place, and how these supports are communicated and/or used by families; and gaps that exist in how transitions are made across programs and across geographic areas.

Types of Transitions

In its most recent (2018-2019) continuation grant application, the USVI Head Start program described three types of transitions: 1) transition from Early Head Start to Head Start; 2) transition from Infant and Toddlers (Part C) to Head Start and Special Education (Part B); and 3) transition from Head Start to Kindergarten. In addition to a focus on these three types of transitions, attention will be given in this section to transition from Kindergarten to first grade. All four types of transitions will be presented within the context of existing supports and gaps to facilitate children's success as they transition from one segment of the Territory's ECE MDS to another (VIDHS 2018-2019 Head Start Continuation Grant).

Transition from Early Head Start to Head Start

As reported in its 2018-2019 HS continuation grant application, the VIDHS notes an existing formal agreement with the EHS program, which operates only in the St. Croix District. On an annual basis, key HS personnel – the Social Services Manager – attends transition workshops organized by EHS, to share information with EHS parents regarding the Head Start Program's eligibility requirements and registration process. To facilitate the registration process for EHS parents, HS personnel handling registration are provided with lists of the children projected to transition to HS from EHS. Based on the lists, appointments are scheduled for parents to begin the registration process to transition their children from EHS to HS. It should be noted that part of the eligibility criteria includes the indication of EHS attendance.

During a key informant interview, the EHS Director further described the transition process and how the EHS parents and children as well as HS and EHS work together to help ensure a seamless approach to the transitioning of children from EHS to HS.

> *So our classes are broken down into three: zero to one year olds, one to two year olds, and two to three year olds, and the teachers follow the children; so, that continuity of care, you know, creating trust and safety. So the teachers will tract the children for those three years. When they get to the two to three classrooms, during the eighth month of that school year, the Family Community Coordinators would be in communication with Head Start. And they would establish a meeting for the parents of the children who will be transitioning into Head Start. At this meeting, members of Early Head Start and Head Start are present and Head Start brings all the required paperwork and documents that the parents will need to complete. They tell them about the curriculum that's used, and how it coincides with what the children are currently using at Early Head Start. It just provides for a smooth transition. After that meeting of the eighth month, two weeks later, there's a field trip and we take the children and the parents -- the parents are also welcome to come along. If the parents have the paperwork completed after those two weeks, they bring it along with them for the field trip. And then the children to spend the day. They meet their potential upcoming teachers at Head Start. Head Start usually provides them with a snack. You know, they spend the whole day there, and then they come back*. [KI, EHS Director, August 2019]

Transition from the Infant and Toddlers Program (Part C) to Head Start or other Private ECE Setting and Special Education (Part B)

The processes and parameters that guide the transition of children from the Infant and Toddlers Program (Part C) to Head Start or a private childcare facility – as determined by the child's parent(s), with the requisite supports through Part B – special education services are based on an Amended Interagency Agreement (herein after, AIA) between VIDOH, VIDE, and VIDHS (2015). The AIA delineates the lead agency for the initiation of the transition process – VIDOH – as well as the specific roles and responsibilities of the other key agencies. The AIA also demarcates the framework within which the agencies collaborate to ensure timely and appropriate identification of services needed by the students, with key personnel from each agency participating in transition meetings with the parents of children transitioning from Part C to HS, with needed Part B services, as captured in the Individualized Education Program (IEP) or the continuation of the child's Individualized Family Services Plan (IFSP) as may be appropriate. The appropriate VIDE Local Education Agency (LEA), as noted in the AIA, must ensure that children who transition from Part C to Part B services are entitled to a free and appropriate public education (FAPE) in the least restrictive environment (LRE). Thus, even if

parents elect to enroll their children in a private/parochial preschool setting, Part B services are to be provided at no cost to the parents/families. [See Appendix IX.]

Since VIDOH is the lead agency for transitions from Part C to Part B services, transition meetings are scheduled by Part C personnel, and representatives from VIDE-State Office of Special Education (SOSE) and VIDHS-HS, to include the HS Disabilities Coordinator (for the respective district) are invited to participate. Once transition meetings have been scheduled with parents and key staff from the three agencies, key information is shared with the parents, to include evaluation and diagnosis information for the child; services available through VIDE-District Office of Special Education (DOSE) to address special needs identified from the evaluation and diagnostic information; the development of the IEP, and the supports available to children during the school day – whether the parent elects to transition their child(ren) from Part C to HS or another parochial/private childcare setting.

During a key informant interview with the Interim Director of the Infant and Toddlers Program, who also provides data support for the program, the team got a description of what is involved in a transition meeting with parents who have children that may need services through Part B. The issue of Part B services being seen as representative of stigma or labeling of children was noted.

> *Part of our transition, we meet with the Department of Education. And as of this summer, I've had two plans - because nothing is forced, nothing is mandatory. You have the right to receive services or even transition. And I've had two plans out of the transition meeting with Department of Education, because they're under the understanding, or I want to say that they're fearful, because, once they hear Department of Education and the special education unit, they feel like it's going to label their child as special needs… we will start the process, and then when it comes time to get other partners as in the center provider out to do the evaluation. And I explained to them that once I get the report, you come back and discuss it. So, they'll open the doors for us to come and do the evaluation, but many times they don't come back to find out what the result was. … And I'm seeing that the under-reporting or our inability to get accurate information is - parents are either fearful of a stigma, or they're in denial that their child is not developing within a reasonable milestone.* [KI, Interim Director, Part C, August 2019]

The transition process begins when the toddler is 2 and a half years old (or earlier as determined by the agencies) to ensure that the requisite IEP or continuation of an IFSP is in place by the child's third birthday and to reduce and/or eliminate gaps in children's receipt of needed services. As described in VIDHS' 2018-2019 HS continuation grant application, the

current transition structure has resulted in insights regarding the expansion of recruitment and transitional services for children with special needs. The way this would work for children with an IFSP transitioning from EHS to HS is captured in the quote below.

> *So …for those with developmental [delays/issues], for example, if we have children in the program, and they have an IFSP, and then they're going on to Head Start, and its continued as an IEP then we do the transition meeting and at the transition meetings, the parents will complete the paperwork, because our children usually have priority…. having a great relationship with the therapists and providers from Infant and Toddlers Program and also Head Start, I think we created a great team and partnership. So we made it a smooth transition for those families who would -- whose children would have an IEP when they transitioned to Head Start*. [KI, LSSVI PAOS, Head; EHS Director, August 2019]

Transition from Head Start to Kindergarten

Like the VIDHS process for the transition of EHS and Part C children to HS, VIDE's SOSE's process for transitioning children with special needs from HS to kindergarten begins with a *Transition Meeting*. Targeted outcomes for the Transition Meeting include: the completion of an IEP for the child; informing parents about the continuum of placement options, both within the public K-12 system as well as the non-public system. Providing parents with information delineating the nature and continuum of services available for their child/children within the public and non-public school system is done to allow parents to make informed decisions regarding enrollment of their child/children in the public or non-public school system. After the parent decides on the school system in which the child/children will be enrolled, an IEP is developed to capture the services the child is to receive during her/his Kindergarten year.

Screening for Readiness to Transition

In the USVI PDG B-5 mixed-delivery system, VIDE administers the LAP-3 to all students transitioning from Pre-K or Head Start to Kindergarten. Information on the number of Head Start children, as well as children receiving services from other types of ECE arrangements/programs are captured in Section III.7, under subheading, *Student Assessment as an Indicator of Progress toward School Readiness*. For SY2018-2019, of the number of Pre-K and Head Start students who completed the LAP-3, 42 students were evaluated for Special Education services. Of those, 28 were determined to be eligible for special education services, so an IEP was developed for each. The other 14 students were deemed ineligible for special education services.

Transition of Special Needs Children from Kindergarten to First Grade

The final group of children for which transition services and supports are provided are for children with special needs transitioning from Kindergarten to first grade. For this group of children, since they would have had an IEP to receive services in Kindergarten, they would automatically be included in an annual IEP meeting. However, transition meetings are convened only for special needs Kindergarten children enrolled in a Transitional (St. Croix) or Therapeutic (St. Thomas) Kindergarten classroom, which is an environment that provides supports needed for special needs children, for up to two academic years to master foundational skills needed to be successful academically beyond Kindergarten. Notwithstanding, whether foundational skills are mastered in one or two years, at the point that children enrolled in a Transitional Kindergarten (St. Croix District) or a Therapeutic Kindergarten (St. Thomas-St. John District) are "ready" to transition to first grade, during the Transition meeting the IEP Team determines the least restrictive environment (LRE) in which to place the children to optimize the likelihood of academic success beyond Kindergarten (AIA, 2015).

Transition Survey

To augment the information on transitions across the USVI ECE MDS, a transition survey was utilized to solicit information about B-5 children transitioning within and across the Territory's current ECE MDS. The anticipation was that, coupling the secondary data related to transition supports with primary data from persons who participate in transition activities, it would be possible to identify the types and nature of supports as well as identify gaps with respect to transition supports in the Territory's ECE MDS. The survey focused on eight areas related to an Early Childhood transition infrastructure: 1) content and scope of services; 2) interagency structure; 3) interagency communication and relationships; 4) interagency agreements; 5) policy alignment; 6) personnel development, staff training and resources; 7) data system and processes; and 8) monitoring and evaluation. Findings based on the transition survey will be summarized within the framework of the eight focus areas. The Transition Supports section will end with an assessment of where the Territory is with respect to transition supports and gaps, based on both secondary and primary data analyses.

Twenty-eight (28) professionals completed the transition survey, titled *Self-Assessment for an Early Childhood Transition Infrastructure (ECTI)* (Appendix III). The typical respondent

was a Black (93%), non-Hispanic (89%), married (50%) female (96%), holding a graduate or professional degree (54%) residing in the St. Croix District. The typical respondent was also a full-time employee (96%) with private insurance through her job (93%), with no children five years or younger in the household (79%). Respondents were primarily persons who are providers within the Territory's ECE MDS, whether in VIDE, VIDOH, VIDHS, or LSSVI.

For each of the eight areas at least three pairs of statements, but no more than six pairs of opposing or polar statements were used to describe the status of the *Early Childhood Transition Infrastructure*. Respondents were asked to "circle the number that aligns most closely to the statement that best describes the USVI ECTI. Table 19 below reflects how the survey items were presented. For all categories of items, lower numbers are associated with more positive statements regarding the Territory's Early Childhood transition infrastructure. While not all focus areas or items are included in Table 19, detailed responses to all items in all eight focus areas are presented in Appendix X.

Table 19

Sample items from the Self-Assessment for an Early Childhood Transition Infrastructure survey

Content and Scope of Services						
Families have access to a broad array of services to support their needs.	1	2	3	4	5	Families lack access to a broad array of services to support their needs.
Interagency Communication & Relationships						
Parent organizations and family consumers meaningfully participate as partners in transition planning efforts at all levels.	1	2	3	4	5	Parent organizations and family consumers are not involved in transition planning efforts at all levels.
Policy Alignment						
Transition requirements and timelines are aligned across agencies.	1	2	3	4	5	Transition requirements and timelines are not aligned across agencies.
Personnel Development, Staff Training and Resources						
We involve parents in the design, implementation, and evaluation of professional development.	1	2	3	4	5	We do not involve parents in the design, implementation, and evaluation of professional development.

The three items related to *Content and Scope of Services* focused on statements relative to access to a range of services and supports, including developmental, educational, health and medical services and supports. For all three items, "3" was the response most selected, with between 39% and 50% of respondents selecting that option, and another 18% – 29% selecting '4' or '5' as responses. This indicates that most respondents felt that families lacked access to the identified array of services and related supports.

With respect to *Interagency Communication & Relationships*, items focused on effective communications between and across agencies; effective working relationships among agency/program staff; and meaningful participation of parent organizations and family consumers in transition planning efforts. Findings reveal that, much like the items related to *Content and Scope*, "3" was the response most selected, with between 39% and 43% of respondents selecting that option, and another 25% to 36% selecting "4" or "5" as responses. Again, these responses do not suggest endorsement for effective interagency communications and relationships in the Territory's current ECE MDS as it relates to transition supports.

For all remaining areas of focus, "3" was the response most selected (both the median and modal response). For areas related to *Data Systems and Processes* and *Monitoring and Evaluation*, Interagency Structure, and Personnel Development, Staff Training and Resources, there was at least one item that at least one-third of respondents selected "1" or "2" responses, reflecting agreement with the positive statements rather than the negative statements. The lack of strong endorsement for the positive statements to describe the eight areas of focus for the transition survey suggests that opportunities exist, as the Territory moves to strengthen the current ECE MDS to bolster transition supports and address existing gaps.

Additionally, while there is an existing AIA related to the transitioning of Part C children to Part B services and the roles and responsibilities of key agencies are delineated, as well as requirements to engage parents, there are no similar detailed processes for B-3 or B-5 children who are DLLs or children moving from ECE settings to the K-12 system, and more specifically to Kindergarten classrooms. The AIA could serve as a model to expand transitional supports for other vulnerable children in ECE settings to optimize the likelihood of seamless transitions from ECE environments to the K-12 system.

Further, though the 2015 AIA is in place, and the VIDE SOSE also has a Procedural Manual (2011) and Revised Special Education Rules and Regulations (2009), the fact that the documents are between five and 11 years old signals that a review of each document may be warranted. More particularly, the current PDG B-5 activities provide an opportunity to revisit all three documents to ensure they are updated and related informational materials developed and shared with all persons who participate in the transition process, beyond the

administrative/managerial personnel specifically designated as part of the transition process. Finally, consideration should be given to an annual parent/family satisfaction survey, to provide feedback to inform the transition process, that is open to all families who have had children transition from the ECE to K-12 system, to include transition from Part C to Part B services, transition from an ECE setting to Kindergarten, or transition from Kindergarten to the first grade.

In considering the implications of the findings from the Transition Survey, it is important to note that only Head Start (HS) personnel from one of the two districts completed the survey. Thus, there may be some important information and nuances related to the transition process that have not been captured by the findings presented. Additionally, no ECE teachers or assistant teachers completed transition surveys, neither did parents who serve on parent councils within HS or EHS. As with some of the findings being only reflective of activities in one district, with respect to HS personnel, there may be value in exploring perspectives of ECE teacher and assistant teachers, as well as those of parents who may be aware of the transition process due to participation on parent councils. Those perspectives could help inform how the transition process is addressed in the Territory's ECE MDS Strategic Plan. This area will be further explored during the strategic planning process, with intentionality, to ensure that these stakeholders have another opportunity to share their perspectives with respect to transition processes across the Territory's ECE MDS.

III.9. Early Childhood Care and Education Facilities

This section of the Needs Assessment describes concerns or issues related to ECE facilities in the U.S. Virgin Islands. Understanding where the Territory is at this time with respect to ECE facilities is important, on the heels of the two recent Category 5 Hurricanes that ravaged the islands, the anticipated extended recovery, and the projection of more intense hurricanes driven by climate change.

Status of Early Childhood Care and Education Facilities Pre and Post Hurricanes Irma and Maria

Based on information from the VIDHS Office of Childcare and Regulatory Services (OCCRS), prior to Hurricanes Irma and Maria, there were 221 licensed facilities that provided childcare services to children across the Territory – 104 in the St. Croix District and 117 in the St. Thomas-St. John District. Of these, 90 and 94 served the B-5 population in the two districts, respectively. Based on data received from VIDHS OCCRS, for SY2019-2020, there were **84** licensed childcare facilities in the Territory – to include HS and EHS centers – **39** in the St. Croix District and **45** in the St. Thomas-St. John District (*not including facilities that cater exclusively to after school programs*). Of the **39** licensed facilities in the St. Croix District, **30** cater exclusively to the B-5 population, while the remaining nine provide services to a wider age range, from as young as birth through age 15. In the St. Thomas-St. John District, **35** cater exclusively to the B-5 population, with the remaining **10** supporting a wider age range, like the facilities in the St. Croix District (Figure 34.1). A detailed listing of the facilities that serve the B-5 population is included as Appendix XI.

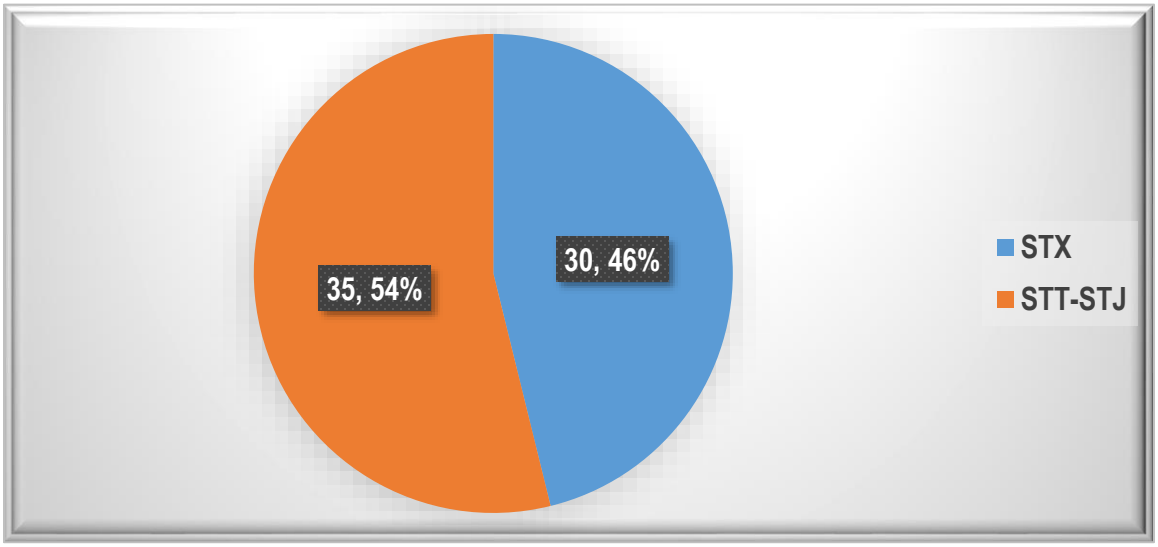
The Region II Head Start Association issued a White Paper in 2019 that provided some insight into the status of licensed childcare facilities in the U.S. Virgin Islands in the aftermath of Hurricanes Irma and Maria, two Category 5 hurricanes that caused significant damage across the Territory in September 2017. The Territory is still in a state of recovery. The report, based on interviews with 25 early childhood professionals – about half of the participants were from St. Thomas (12); seven from St. Croix; and six from St. John – revealed, that, as late as summer 2019, 56% of respondents indicated that they had changed their hours of operation, while 16% noted changes in the locations of their facilities. Respondents had an average of approximately 20 years in the childcare field, with the majority holding positions of Lead Administrator (Director or Owner) of the facilities. Fully 92% of respondents reported

hurricane-related damage or destruction to their facilities, to include roof and window damage; playground damage; water damage, including flooding; outdoor equipment ruined; and materials and supplies destroyed.

In response to a question regarding hurricane preparedness plans, just over one-third – 36%, indicated that prior to the 2017 hurricanes they did not have preparedness plans in place and as of summer 2019, had not developed preparedness plans. Respondents also expressed a need for supplemental resources related to protocols for addressing various emergency situations; resources to address emotional and mental health, environmental health, and water safety issues; and resources that could help children cope with natural disasters (p. 9).

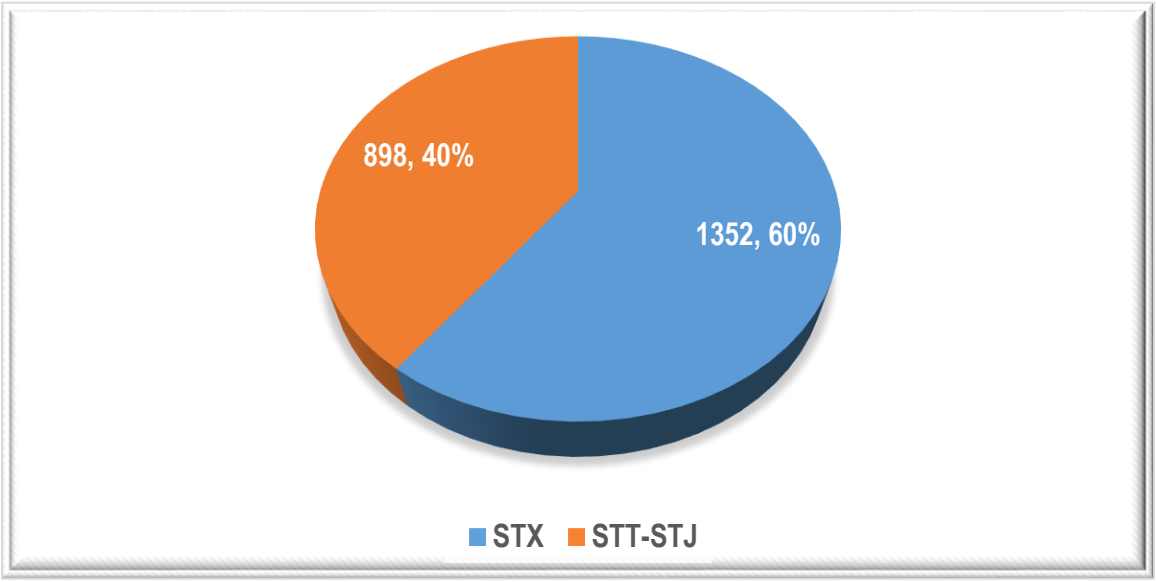
During focus group discussions conducted with HS and EHS teachers and middle managers in the aftermath of Hurricanes Irma and Maria to update a 2016 environmental scan completed of the HS/EHS programs in the USVI, researchers at the Caribbean Exploratory Research Center received information documenting the destruction of all playground equipment at Head Start centers across the Territory and the closure of the Minetta Mitchell center on St. Thomas – which housed five (5) classrooms, the Kirwan Terrace HS center, and the St. John HS center. All three centers remain closed. Additionally, while three of the five Minetta Mitchell classes have been relocated to the Sugar Estate Complex, the St. John center has not reopened, and those children were not reassigned to other HS centers. In addition, on St. Croix, two Head Start centers remain closed.

Figure 34.1. **Licensed Facilities Serving the USVI B-5 Population by District: SY2019-2020**



Figures 34.1 and 34.2 further capture information about ECE facilities. The St. Thomas-St. John District has a larger number of licensed childcare facilities (54%) to support the B-5 population in the USVI (Figure 34.1), however, the capacity in terms of number of B-5 children that can be served by the licensed childcare facilities is 50.5% more in the St. Croix District than in the St. Thomas-St. John District (Figure 34.2).

Figure 34.2. **Capacity of Licensed Childcare Facilities Serving the USVI B-5 Population: SY2019-2020**



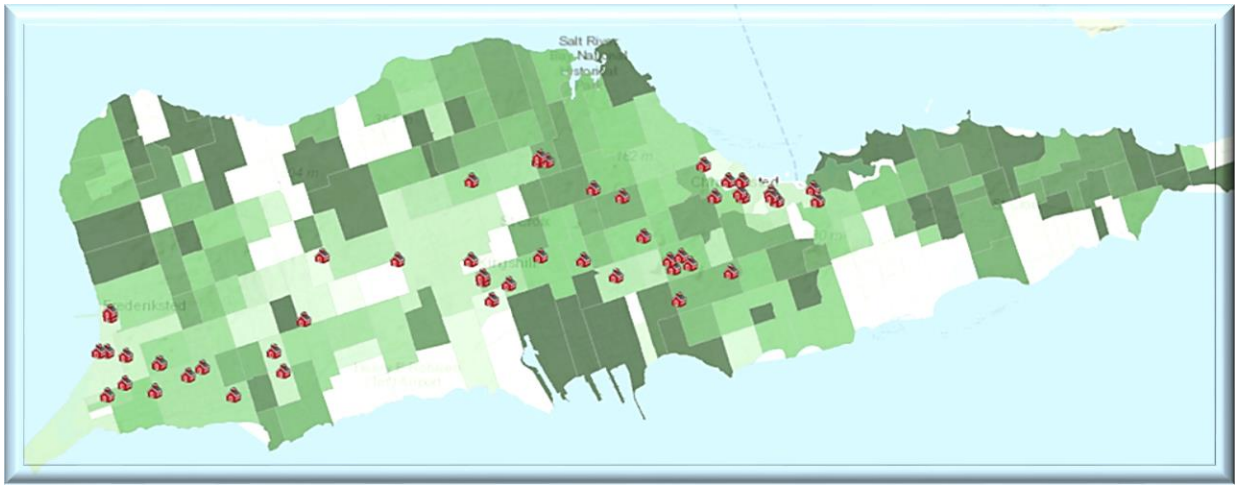
Currently, EHS is offered only in the St. Croix District though efforts have been made to expand the program to the St. Thomas-St. John District. The reasons for the lack of program expansion are primarily related to facilities challenges, as shared during a key informant interview.

> *And as far as capacity within that program, we have tried writing grants, and we do very well in writing those grants. The problem is, and what always gets us is, the federal government won't just give you money to build a new facility. So they will, if you have an existing facility, or if you could rent a facility -- because you have to have site control. If you could have the facility that you can get, I guess, five to 10 years lease agreement, they might agree to giving you a grant if, in a nut shell, funding that you require for renovation, is reasonable. And so a lot of times, the times we've tried to apply saying that …to build us some buildings because we didn't have an official commitment, we weren't granted. So it's been very, very challenging to expand the program whether it be here or on St. Thomas because of the fact that, 1) there is a 20% -- it's actually 25% when you do the math and if you match your own match 20% requirements funding, and you have to have an adequate facility with adequate spacing because they're very specific about the spacing per child.* [KI, PAOS Head, LSSVI, August, 2019)

Location of Early Childhood Care and Education Facilities across the U.S. Virgin Islands

Figure 35.1 shows the locations of licensed childcare facilities on the island of St. Croix. Many of these facilities are clustered in the following Census sub districts: Southwest, Frederiksted, Christiansted, Anna's Hope Village, Sion Farm, and Southcentral. On St. Croix, Sion Farm, Southwest, and Southcentral are the most heavily populated sub districts on St. Croix. While Christiansted is not as densely populated, the clustering of licensed childcare facilities in this geographic area could likely be explained by the need to have facilities to support persons who work in the area.

Figure 35.1. **Locations of Licensed Childcare Facilities on St. Croix: SY2018-2019**



A perusal of Figure 35.2 reveals that most of the licensed childcare facilities on the island of St. Thomas are clustered in the Census sub districts of Charlotte Amalie, Tutu, Southside, and East End. There are very few licensed childcare facilities in the Northside Census sub district and none in the West End Census sub district, indicating a childcare desert in this Census sub district. On St. Thomas, the most densely populated Census sub districts are Charlotte Amalie, Northside, Tutu and East End. The clustering of licensed childcare facilities in Charlotte Amalie and Tutu speaks to both the population density and employment locations.

Figure 35.2. **Locations of Licensed Childcare Facilities on St. Thomas: SY2018-2019**

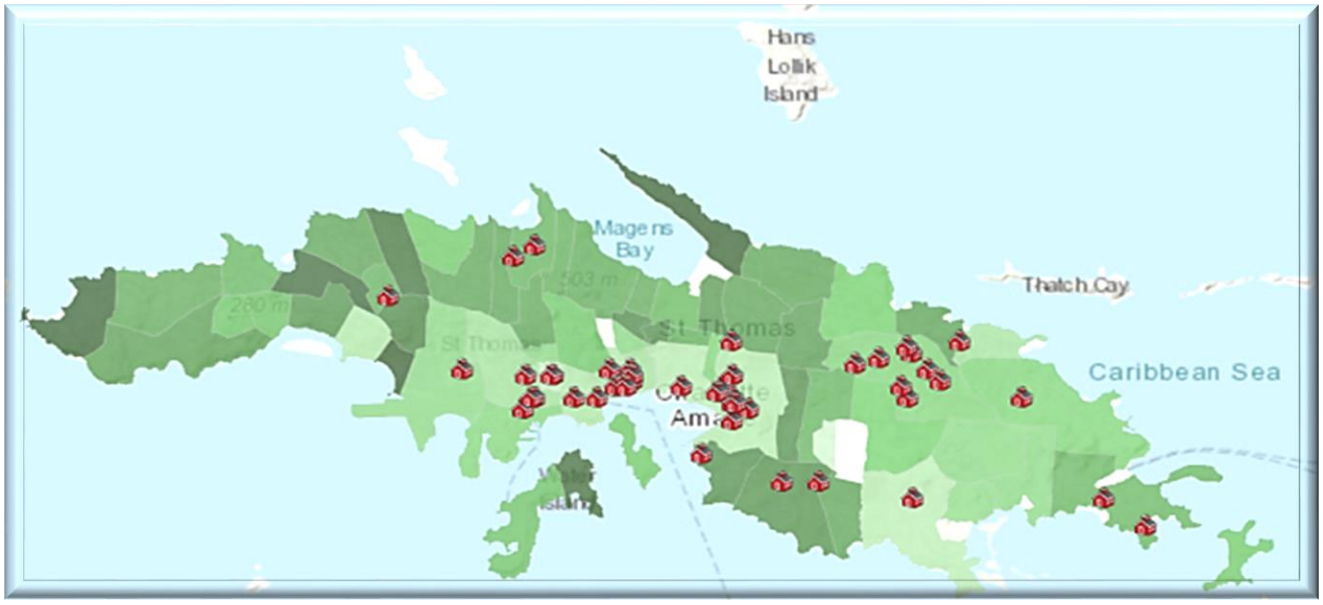
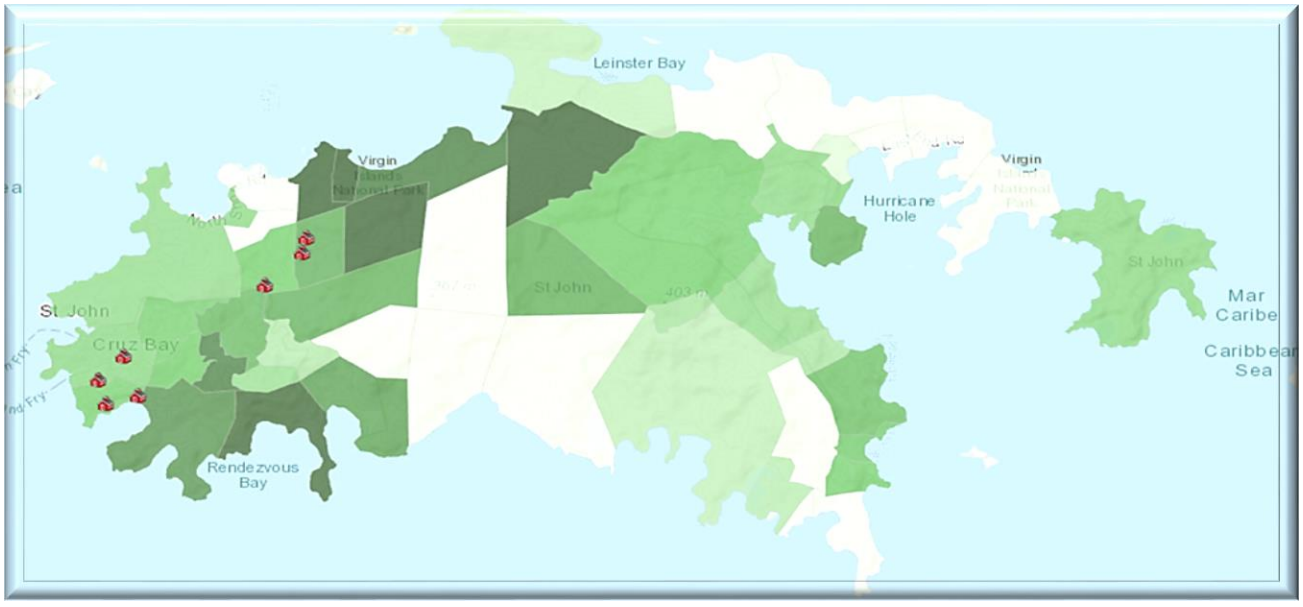


Figure 35.3 shows the locations of licensed childcare facilities on the island of St. John. As can be noted from Figure 35.3, there are very few licensed child facilities with most clustered in the Cruz Bay Census sub district and the remaining in the Central Census sub district. The population of St. John is a fractional part of St. Croix and St. Thomas, with fewer than 3500 persons residing on that island. The most densely populated Census sub district is Cruz Bay, which is where most of the licensed childcare facilities on St. John are located. The remaining licensed childcare facilities are in the Central sub district

Figure 35.3. **Locations of Licensed Childcare Facilities on St. John: SY2018-2019**



An important aspect of licensed childcare facilities on St. Thomas, and to a lesser extent, on St. John has to do with the locations in terms of challenges with easy access relative to parking due to the density of the locations and terrain in which many of the facilities are located. This results in challenges with respect to parking, so that in some instances, parents/guardians are rushing to drop children off as well as to pick them up, which is not conducive to parents being able to easily spend time at the facility to observe their children in the childcare setting or visit with caregivers. This challenge is not as present on St. Croix, which is the largest of the three islands and where most childcare facilities would be able to accommodate parking for parents who wanted to spend some time on site.

The data presented in this section of the Needs Assessment reveal that though fewer licensed childcare are operational in the St. Croix District, those facilities have a higher enrollment capacity than the facilities in the St. Thomas-St. John District. This is not surprising, given the realities of the size and terrain of both St. Thomas and St. John, as well as the price of real estate rental and/or ownership in the two districts, with costs of commercial real estate being significantly higher on St. Thomas than on St. Croix, and higher yet, on St. John, compared to St. Thomas. So, in most instances, childcare facilities on St. Croix will be larger, in terms of square footage, than those on St. Thomas or St. John.

The data further reveal that, over a year and a half after the significant disruption and destruction caused by Hurricanes Irma and Maria, two Category 5 hurricanes that struck the USVI in September 2017, many childcare facilities have still not recovered 100% from the destruction, with several that closed not reopening, and even Head Start still having reduced classrooms due to the closure of multiple centers across both districts. Playground equipment, important for child development, is still absent from the majority of childcare facilities.

Finally, within the context of COVID-19, there are implications for child care access and availability, given the points made regarding the size of many of the childcare facilities in the St. Thomas-St. John District and what this will likely mean for the number of children who can safely be cared for in existing facilities. This coupled with the current hurricane season, which is expected to be an active one, has the potential for ongoing facilities' challenges for the Territory's ECE facilities and their owners/operators, whether public, private, or parochial.

III.10. Early Childhood Care and Education Funding and Resource Use

Within the USVI, funding for ECE programs and services is derived from multiple sources, with a substantial amount of funding coming from the Federal Government. Federal funding which requires a match by the Government of the Virgin Islands in support of ECE programs and services in the Territory is also noted. This section of the Needs Assessment highlights available funding within the Territory's ECE mixed-delivery system and speaks to how resources are used to address the B-5 population.

Funding for Early Childhood Care and Education in the USVI

Federal funding for ECE programs and services in the U.S. Virgin Islands is provided by three federal agencies. First, the Department of Health and Human Services (DHHS), through the Administration for Children and Families (ACF), funds Head Start, Early Head Start, and the Child Care and Development Fund, which provides childcare subsidies to qualified families. The DHHS, through HRSA, also funds the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program administered by the VIDOH MCH & CHSCN Program, and the WIC program, also administered through the VIDOH. Second, the U.S. Department of Education (ED), through the Office of Special Education Programs (OSEP), provides funding for Part C and Part B programs. The ED also funds the Rural and Low-Income Schools (RLIS) Program (Table 20).

At the local level, Part C, the Infant and Toddlers Program, is administered by the V.I. Department of Health and serves children B-3. Part B, which provides special education programs and services to children ages three to 18, is administered by the V.I. Department of Education (VIDE), with the State Office of Special Education (SOSE) having oversight and ensuring compliance with federal requirements by the Local Education Agencies (LEAs) – responsible for the delivery of special education programs and services in each district through the District Offices of Special Education (DOSEs).

Third, and final, the U.S. Department of Agriculture (USDA), through the Food and Nutrition Service, supports WIC, SNAP, and the School Breakfast Program and the National School Lunch Program. The three programs are administered through the Departments of Health, Human Services, and Education, respectively. Funding from the USDA flows through the three local agencies that have specific responsibility for nutrition for the B-5 population – VIDOH which administers the WIC program; VIDHS which administers the SNAP program,

and VIDE which administers the National School Lunch Program and the School Breakfast Program.

Table 20

Funding and Funding Sources for ECE* in the USVI: FY 2018-2019

FUNDING STREAM	DESCRIPTION/PURPOSE	FED AGENCY	FUNDING TO USVI	NOTES
TOTAL [ALL SOURCES, ALL AGENCIES, ALL PROGRAMS]			$83,211,981	
Flow of Funds: VIDHS				
SUBTOTAL			$38,308,718	
ACF-OCCRS CCDF	**Childcare** subsidies; childcare services; administrative	DHHS	$5,134,815	
ACF—OPRE; HS & HS Disaster Recovery [HSDR]	Head Start Program - Promotes school readiness for children under 5 from low-income families. To purchase vehicles for the Head Start Program [HSDR].	DHHS	$8,621,787	Local match required [LMR] – 20%
		DHHS	$727,586	
CMS-CMCS	CHIP	DHHS	$10,947,551	Represents 2-year period
	CHIP Redistribution	DHHS	$2,939,613	
SNAP	To ensure healthy food choices for eligible low income families	USDA	$7,096,670	
ACF-OCCRS	PDG B-5	DHHS	$725,112	LMR
ACF-TANF	TANF - Provides monetary support for employment & training assistance, cash and energy assistance to needy families	DHHS	2,837,170	LMR – 25%
Flow of Funds: LSSVI				
ACF—OPRE	USVI EHS Program	DHHS	$2,159,534	LMR – 20%
Flow of Funds: VIDOH				
SUBTOTAL			$10,950,207	
Immunization		DHHS	$2,008,688	
HRSA-MCH Block grant	To improve and maintain the health status of women, infants, children, and adolescents	DHHS	$1,204,355	
HRSA-MIECHV	Supports at-risk pregnant women and families; promotes well-being of infants	DHHS		
OSEP Part C	Early intervention services for infants and toddlers with disabilities	ED	$794,159	
FNS WIC	To ensure healthy food choices for eligible low income expectant mothers and infants	USDA	$6,943,005	
Flow of Funds: VIDE				
SUBTOTAL			$31,071,936	
Title V-Part B Subpart 2	Rural/Low-Income School (RLIS) Program	ED	14,691,336	
OSEP – IDEA	Part B	ED	8,645,926	
OSEP – IDEA Sec 619	Part B for ages 3 – 5	ED		Amount N/A
FNS	School Breakfast and National School Lunch Program	USDA	7,734,674	

**Note: Public ECE only; Data sources – GVI FY 2019 Executive Budget & administrative data from VIDE & VIDHS*

Though the overall total noted for the funding captured in Table 20 is approximately $83.2 million, it is important to point out that this total is not 100% targeted to the B-5

population. With the exception of HS, EHS, and the PDG B-5 funding streams, all other funds support children beyond age five as well as adults, to include pregnant women (some supported by EHS), and non-working mothers (TANF and childcare subsidies). Most programs do not have data specifically disaggregated in a way that allows for distinguishing costs associated with programs and services specifically to children B-5, except if funding is provided within that narrow framework. There was also no data available that suggests that there is any blending of resources across local government agencies to support programs and services for the Territory's B-5 population.

However, specific data were available to demonstrate support for the B-5 population though the Medical Assistance Program (MAP) and the Child Health Insurance Program (CHIP), which represent the primary mechanisms through which children B-5, who are insured through MAP, receive financial support to timely address their primary health and medical needs. This funding also supports specialized care, which, based on the nature of the health/medical need, may require that services be accessed out of the Territory. Once eligibility has been determined, all related expenses are covered by MAP/CHIP. Figures 36.1 and 36.2 capture the level of MAP funding for services to children B-5 over the past five fiscal years, with Figure 36.1 capturing funding for all children and Figure 36.2 capturing financial support for children B-5 with special needs. The graphs represent unduplicated numbers in terms of fiscal support provided.

Figure 36.1 reveals that, with the exception of FY2016-2017, more funds were expended in support of B-5 children in the St. Thomas-St. John District than in the St. Croix District. Further, Figure 36.1 reveals that for the two fiscal years after Hurricanes Irma and Maria, there was a marked increase in the funds expended for out-of-Territory care for children B-5, triangulating with information shared by health providers in focus group discussions and FQHC administrative personnel regarding the lack of pediatric specialists in several key areas, partly due to providers leaving the Territory in the aftermath of the Hurricanes. In contrast, Figure 36.2 reveals that out-of-Territory expenditures for services for special needs children declined sharply in FY2015-2016 and remained relatively flat through FY2018-2019. However, as with expenditures for the overall B-5 population, Figure 36.2 reveals that for four of five fiscal years represented, more funds were expended to support special needs children in the St. Thomas-St. John District than in the St. Croix District.

Figure 36.1. **MAP funding for Services to Children Ages B-5 by Location of Services: FY2014-2015 to FY2018-2019**

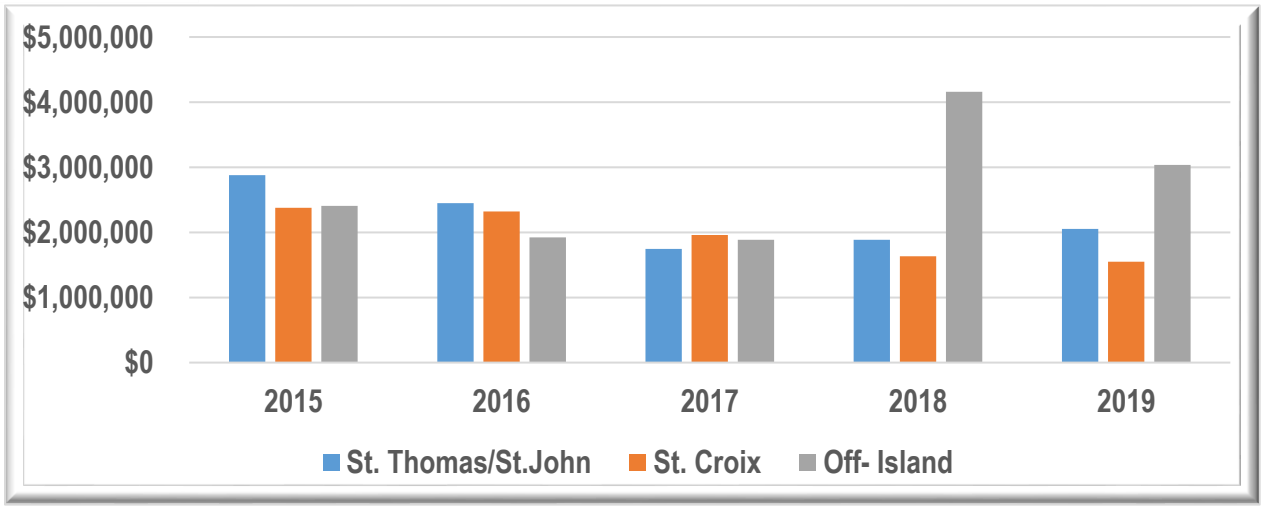
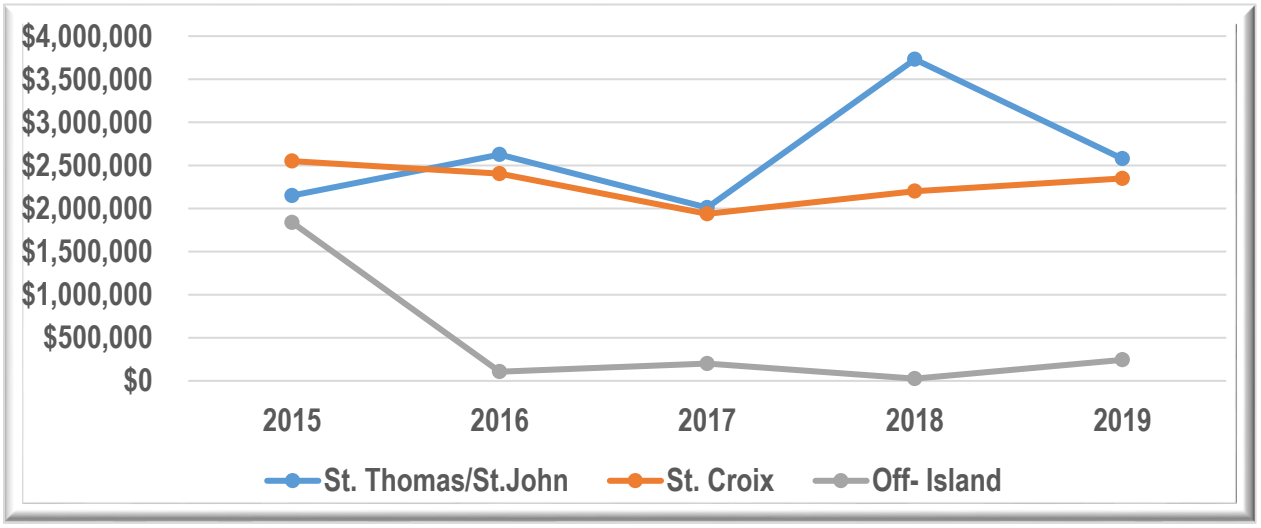


Figure 36.2. **MAP Funding for Services to Special Needs Children Ages B-5 by Location of Services: FY2014-2015 to FY2018-2019**



While this section of the Needs Assessment provides an overall picture of the public funding and resources in place to support the Territory's ECE MDS, it is also clear that the data on funding and resource used to optimize programs and services need to be brought into sharper focus. As in other areas, this presents an opportunity for further refinement during the development of the Territory's ECE MDS Strategic Plan.

III. 11. Additional Stakeholder Input

In addition to the information garnered from administrative and secondary data, primary data from various stakeholder groups were collected to augment these data. What follows is a summary of the information gathered from stakeholder groups. In presenting the information, links will be made between the information received from stakeholders on key areas and the information provided from administrative and secondary data.

General Stakeholder Survey

A general stakeholder survey was used to capture information from stakeholders with respect to their perspective on how current policies and programs in the U.S. Virgin Islands are meeting the needs of infant, toddlers and their families. This survey was identified through a publication by Halle and Vick (2007) which provides information on various measures used to assess quality in ECE settings. Four broad categories are covered in the survey: collaboration and system building; positive early learning experiences; strong families; and health (Appendix III). As noted in Table 1.1 (p. 12), over 550 stakeholders participated in various data collection efforts to support the development of the Needs Assessment. Of that number, 88 completed the general stakeholder survey. Respondents included owners/operators of day care center; elementary school counselors and administrators; first grade teachers; family members of children B-5 (not parents); and other persons working in the Territory's ECE MDS. A perusal of Table 21.1 shows that the typical stakeholder respondent was a Black, non-Hispanic female, 40 years of age or older.

Table 21.1
Demographic Characteristics of General Stakeholder Group

Characteristic	Category	Number (Percent)*
Age Group	18 - 29	10 (12)
	30 - 39	13 (15)
	40 - 49	22 (25)
	50 and Older	42 (48)
Sex	Female	80 (92)
	Male	7 (8)
Race	Black	78 (91)
	Other	8 (9)
Ethnicity	Hispanic	7 (8)
	Not Hispanic	77 (92)

**Note: Percentages are based on the number of persons responding to an item. Sample size: n=88*

With respect to family composition, the typical respondent had no children 5 and under in the home; was married and in a family of three or fewer members (Table 21.2).

Table 21.2
Family Composition of General Stakeholder Group

Characteristic	Category	Number (Percent)*
Marital Status	Single, never married	31 (36)
	Married	36 (42)
	Divorced	11 (13)
	Other *(domestic relationship; separated or widowed)*	8 (9)
Family Size	2	33 (39)
	3	25 (30)
	4	17 (20)
	5 or more	9 (11)
Children B-5 in Family	None	72 (82)
	1	10 (11)
	2	3 (3)
	3 or more	3 (3)

**Note: Percentages are based on the number of persons responding to an item. Sample size: n=88*

With respect to socio-economic characteristics, the typical, general stakeholder respondent was a full-time employee with private insurance, earning over $50,000 annually. Just over half of the respondents (53%) resided in the St. Thomas-St. John District (Table 21.3).

Table 21.3
Socio-economic Characteristics of General Stakeholder Group

Characteristic	Category	Number (Percent)*
Island of Residence	St. Croix	41 (47)
	St. John	5 (6)
	St. Thomas	41 (47)
Employment Status	Employed, full-time	77 (88)
	Employed, part-time or self-employed	7 (8)
	Other (retired or 'other')	4 (4)
Annual Household Income	Less than $35,000	15 (17)
	Less than $50,000	25 (29)
	Less than $75,000	21 (24)
	$75,000 or greater	21 (24)
	Not sure	5 (6)
Type of Insurance	Private, through job	65 (76)
	Public (Medicaid or Medicare)	3 (3)
	Uninsured	8 (9)
	Other (self-insured or 'other')	10 (12)

**Note: Percentages are based on the number of persons responding to an item. Sample size: n=88*

What is presented next are summaries of stakeholders' perceptions of current ECE policies and programs in the areas of collaboration and system building, positive early learning experiences, strong families, and health are meeting the needs of the infant, toddlers, and their families. Detailed responses to all survey questions are captured in Appendix XII.

Collaboration and System Building

The first series of statements address ***collaboration and system building*** within the Territory's ECE MDS. Stakeholders responded to statements regarding how current policies and programs promote collaboration (2); recruit and engage stakeholders (4); define and coordinate leadership (4); ensure accountability (5); enhance and align standards (2); create and support improvement (5); and finance strategically (3). The numbers in parentheses represent the number of statements in each of the subcategories. For all statements, responses were based on the following scale:

Have not started to address this goal	***Have started to initial conceptual and planning work***	***Have begun to implement***	***Have made solid progress***

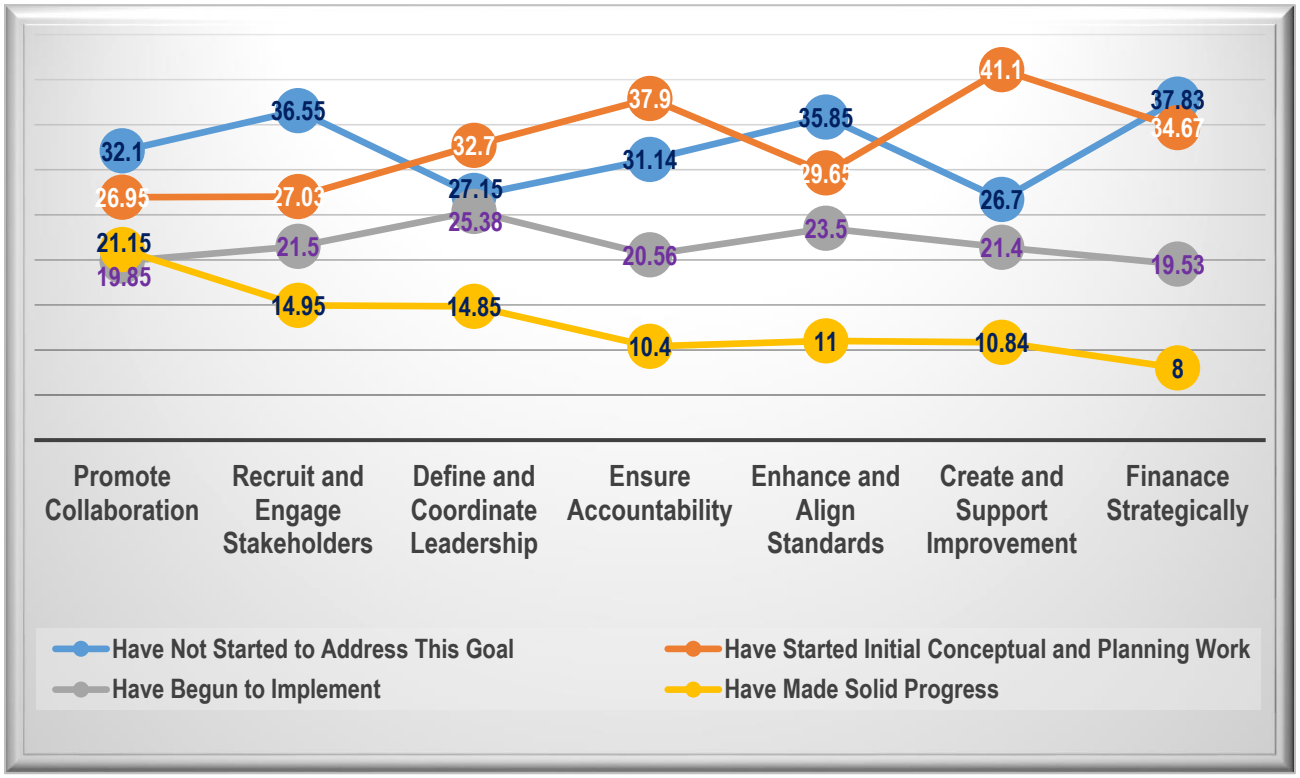
The statements associated with "***promote collaboration***" focus on transition policies and continuity of services as well as linkages between ECE programs and other services such as mental health and education. Statements addressing "***recruit and engage stakeholders***" revolve around having diversity of stakeholders engaged in the Territory's ECE MDS, public awareness about the needs of infants and toddlers, persons who champion investing in high quality infant-toddler programs, and influential policymakers who support ECE system building in the Territory. Under "define and coordinate leadership" statements focus, in part, on the existence of state-level governance entity that oversees and coordinates ECE services and programs in the Territory; an ECE SAC that focuses on the needs of infant and toddlers; and governmental and nongovernmental leaders that promote improving policies for infants and toddlers.

In the area of "***ensure accountability***" all statements focus on the state's/Territory's efforts to support the existing ECE MDS as reflected by a shared vision to support young children and their families; the identification of desired outcomes for infants and toddlers and related indicators to determine whether outcomes have been met; the existence of an integrated ECE plan that is reviewed regularly; and a coordinated early childhood data system. With respect to "***enhance and align standards***", the statements focus on whether

the Territory has completed a cross-walk of infant and toddlers programs and how they align and are supported by research, and whether quality improvement strategies, quality rating systems, and professional development efforts are aligned with each other rather than parallel. In the subcategory of "***create and support improvement***", three of the five statements relate to the creation of career pathways and professional development opportunities for persons in the infant-toddler workforce. The other two statements relate to state support for quality improvement for infant-toddler programs and continuous improvement of services to the B-5 population and their families. With respect to "***finance strategy***", the three statements included in the survey speak to stable funding being available to strategically address the needs of infants and toddlers.

Figure 37, below, provides a graphic representation of average percentages of stakeholders' responses to the seven categories of statements that addressed stakeholders' perspectives on how current policies and programs are meeting the needs infants, to support ECE ***collaboration and system building***.

Figure 37. **Average percent of stakeholders indicating progress policies in support of *collaboration and system building* within the Territory's ECE MDS**



A review of Figure 36 reveals that, overall, stakeholders do not believe that the Territory has made "solid progress" in the area of ***collaboration and system building*** within the Territory's ECE MDS, though, at least one in five felt that "solid progress" had been made in the area of promoting collaboration. Additionally, within the overall area of collaboration and system building, stakeholders perceived the least progress in the areas of strategic financing of the Territory's ECE MDS, recruitment and engagement of stakeholders, and the enhancement and alignment of standards, with over one in three stakeholders, on average, indicating that the Territory had not started to address those areas, while only between 8 and 15% of stakeholders felt that the Territory has made "solid progress" in these areas.

Given the focus of the PDG B-5 to strengthen collaborations within the ECE MDS, as well as engaging stakeholders, some more focused findings are presented in these two areas. With respect to whether existing policies ***promote collaboration***, one in three respondents felt that the Territory had begun to implement transition policies to ensure continuity of services between various infant-toddler settings or had made solid progress in this area. Almost half of the respondents (46%) indicated that mechanisms exist in the Territory to coordinate among infant-toddler programs and to link them with other services.

With respect to whether existing policies support the ***recruitment and engagement of stakeholders***, 45% of respondents (35 of 78) indicated that the Territory's ECE MDS development efforts "involve diverse representation from stakeholders from both public and private sectors" who are interested in infants and toddlers. However, with respect to areas such as *public awareness of efforts to build public and political will to support the needs of infant and toddlers*, *having champions promoting investment in high-quality infant and toddlers' programs*, and *influential policymakers supporting ECE system development in the Territory*, only about one in three respondents felt that existing policies supported such efforts.

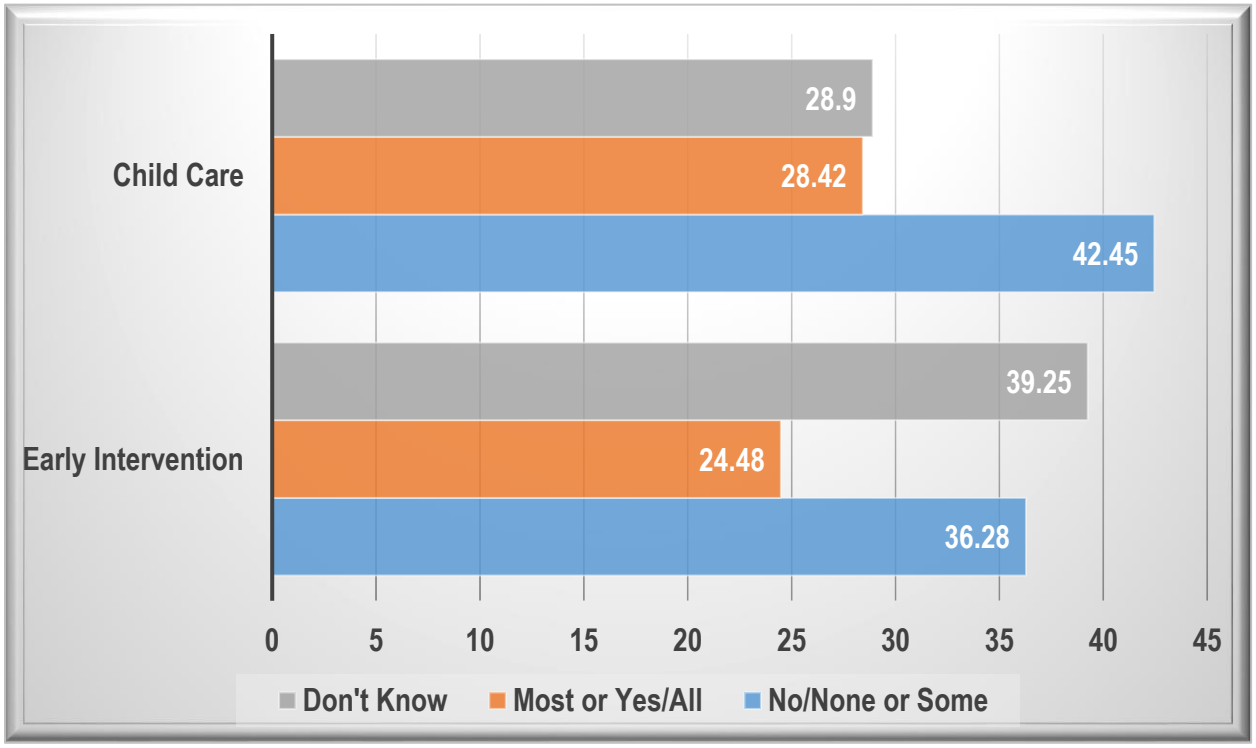
Stakeholders then responded to questions related to policies and programs within the Territory's ECE MDS that focus on ***positive early learning experiences***, ***strong families***, and ***health***. For these three broad categories, response options differed from those for the sections related to collaboration and system building. For all statements, responses were based on the following scale:

No/None	***Some***	***Most***	***Yes/All***	***Don't Know***

Positive Early Learning Experiences

Figure 38, below, provides a graphic representation of average percentages of stakeholders' responses to the two categories of questions that addressed stakeholders' perspectives on how current policies support ***positive early learning experiences*** within the Territory's ECE MDS. The two subcategories related to positive early learning were "***early intervention***" and "***child care***". The four statements related to "***early intervention***" focused on supports for children with potential developmental disabilities or delays, supports for children who have been victims of child abuse, and systems in place to support these children. The survey included 10 statements related to "***child care***" which ranged from statements regarding cultural responsiveness of child care programs, to the engagement of families and support for parents, to families' ability to access quality care for their children, among others.

Figure 38. **Average percent of stakeholders indicating policies and programs exist within the Territory's ECE MDS to support *positive early learning experiences***



The most striking fact revealed from a review of Figure 38 is that the largest, average percentage of stakeholders responded "Don't Know" to statements related to early intervention support infants and toddlers in the Territory's existing ECE MDS. Additionally, more than one in three stakeholders do not believe that all the necessary supports are in place for children with special needs. Further, with respect to statements related to the accessibility of childcare

and the engagement of families, just over two in five stakeholders felt that level of accessibility and other supports are either not in place at all, or not fully in place. Approximately two in five stakeholders did not feel that they had sufficient knowledge about the Territory's ECE MDS to respond to the statements describing the system.

Strong Families

Stakeholders also responded to a series of statements related to the area of ***strong families***, which included five sub-sections – policy, basic needs, home-visiting/parent education, child welfare, and family leave. Statements (4) relative to "***policy***" address families' ability to find needed services based on referrals; families receive information in their home culture and language; families whose children have multiple risk factors can access needed services; and, the Territory's ECE MDS has policies that speak to multigenerational approaches to addressing at-risk children's needs.

"***Basic needs***" statements (3) address access to needed education, training and job opportunities, as well as housing options, and energy assistance. Statements relative to "***home visiting/parent education***" focus on the availability of evidence-based, home-visiting programs and parent education programs for families with infants and toddlers; the availability of supports for FFNs taking care of children of working parents; and supports available for parents who would like resources to support them in caring for the infants and toddlers.

The five statements relative to "***child welfare***" focus on the care and supports available to children in placements or who are a part of the child welfare system, appropriate screenings and services, and investigations of instances of suspected maltreatment. The three statements relative to "***family leave***" focus on working families access to paid leave in instances of a birth or adoption, or needing to care for a sick child; and work-life balance options for working parents to allow for caring for young children.

Figure 39. **Average percent of stakeholders indicating policies and programs exist within the Territory's ECE MDS to support *strong families***

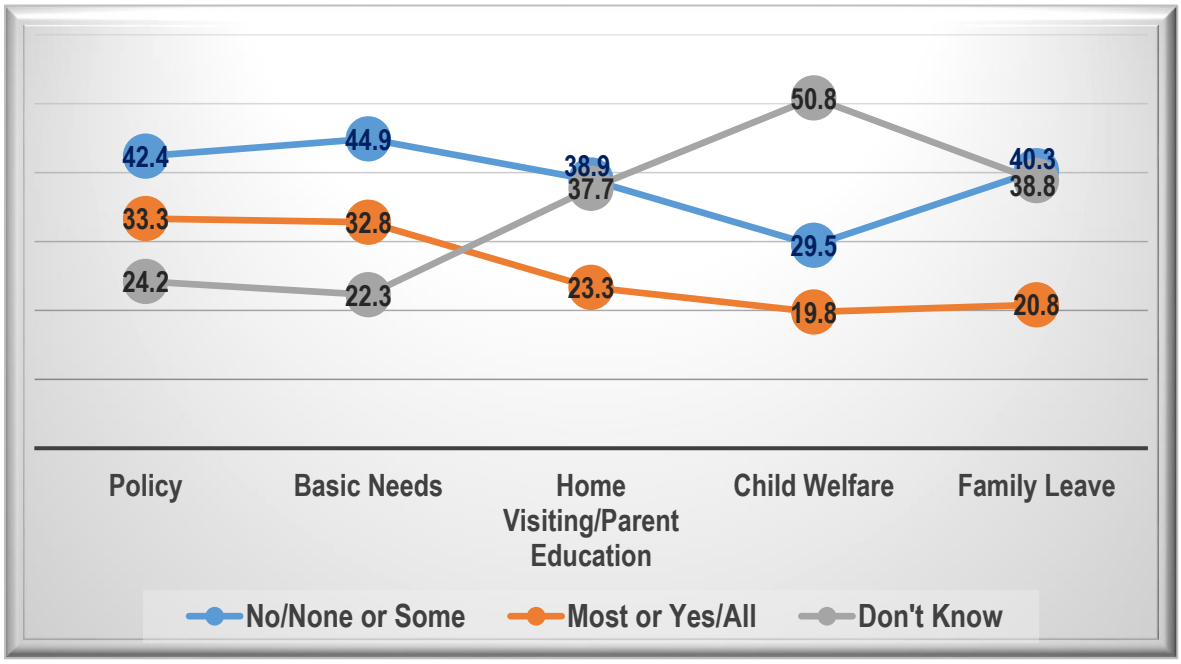


Figure 39 captures average percent responses of stakeholders regarding whether the Territory's ECE MDS has policies and programs that foster strong families through supports in five key areas. With respect to policy and basic needs, just one-third of stakeholders affirmed that supports are available for families to access needed services based on referrals and to address their basic needs. Fully 51% of stakeholders do not know what supports and protections are available for children who are a part of the child welfare system and approximately two in five believe that families have the optimal level of support in the areas of home visiting/parent education and access to needed family leave.

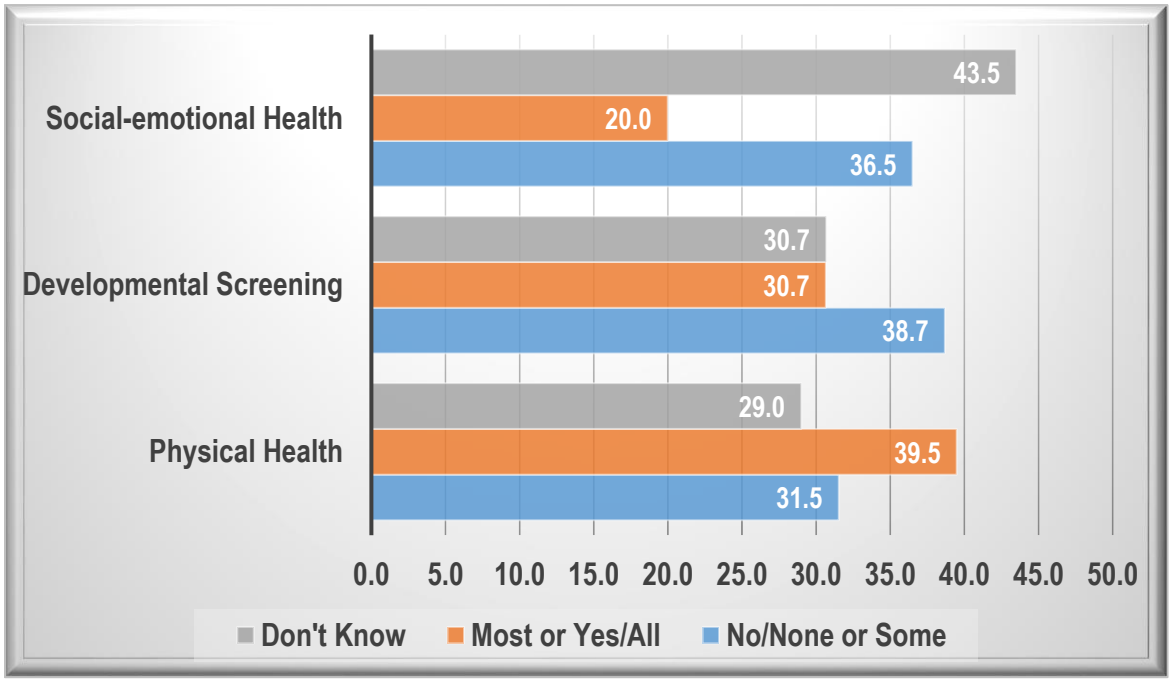
Health

The final category of statements that stakeholders responded to related to the area of ***health*** and included three sub-sections – physical health, developmental screening, and social-emotional health. In the sub-section on "***physical health***", there were nine statements, many of which related to eligible children and families accessing programs such as WIC and SNAP, children having a medical home and getting well-child visits; infants-toddlers being able to access nutritious food and receiving care in healthy environments. There were four statements in the subsection "***developmental screening***" focused on accessibility of developmental screening, appropriateness of services provided based on outcome of

screening, sharing of screening results with providers, and adequate reimbursement of primary providers conducting screenings. In the subcategory "social-emotional health" statements generally focused on the availability and accessibility of mental health services, resources available to parents in support of their children's social-emotional development, and adequate reimbursement for primary care providers who conduct childhood mental health screening.

Stakeholders' average responses to statements in each of the three subareas are captured in Figure 40. With respect to statements about social-emotional health, the majority of stakeholders (44%) indicated "Don't know" in response to the seven statements, while one-fifth felt that families and children had access to and received mental health services from trained professionals. With respect to developmental screening for children with special needs, an equal percentage (31%) of stakeholders responded "Don't know" or "Most or Yes/All" to the statements relative to families accessing developmental screening and appropriate services being provided based on results of screening.

Figure 40. **Average percent of stakeholders indicating policies and programs exist within the Territory's ECE MDS to support *health***



With respect to statements associated with the sub-area, "***physical health***", this was the category where the largest percentage of stakeholders (40%) responded in the affirmative regarding families and children B-5 accessing particular programs, children having a medical

home, and families with young children being able to access nutritious food. Yet, close to one in three stakeholders felt that none or only some of the services are available in the Territory's current ECE MDS. Detailed responses to the Stakeholder Survey are provided in Appendix XII.

State Early Childhood Inclusion Self-Assessment

This self-assessment tool provides a framework for examining key aspects of a State infrastructure that are useful for promoting high quality inclusive practices, programs and policies *(See Appendix III for annotated survey instrument).* The survey was completed by high level decision makers and members of the SAC in the St. Croix and St. Thomas-St. John districts. The self-assessment is useful for examining components of the Territory's ECE mixed-delivery system and the identification of system strengths and gaps.

The response rate for the State Early Childhood Self-Assessment was 23% and this produced findings in which the majority of the respondents acknowledged the existence of a partially implemented or fully implemented *State Interagency Task Force with the authority to create or strengthen early childhood inclusion*. Those respondents also reported that the State Interagency Task Force includes *representatives from different sectors and groups associated with early childhood programs (See a summary of the findings from the Early Childhood Inclusion Self-Assessment in Appendix XIII)*.

Ensure State Policies Support High-Quality Inclusion

With regards to ensuring State polices support high-quality inclusion, the respondents, as a whole, did not provide much evidence to support the eleven sub-questions in this section of the self-assessment tool. One respondent noted that many of the USVI's policies mirror federal rules and requirements governing the programs and, as such, the policies and procedures generally address the identified issues and are partially or fully implemented in the Territory. There was consensus that policies, whether partially or fully implemented, consistently aligned with federal and/or State legal requirements. Additionally, the vast majority of the participants self-reported at least partially implemented policies that *establish early learning guidelines and standards to address the learning and developmental needs of children with disabilities*; as well as partial or fully implemented *current or prospective early learning initiatives that include policies and procedures to recruit, enroll, and support children with a range of disabilities*.

Set Goals and Track Data

According to the findings there are no policies in place, or policies are only in the planning stage that would indicate that *the State Interagency Task Force and their respective agencies establish a baseline that identifies the number of high-quality early learning childhood slots available, and the number of children under five with and without disabilities in those slots.* The question pertaining to *use of data to develop benchmarks to track the progress toward increasing the number of high-quality early childhood program slots available,* was also rated as being in an emergent stage of development. The respondents pointed to the ongoing development of VIVIS and ECIDS as the mechanisms needed to facilitate the use of data for tracking and developing benchmarks.

Review and Modify Resource Allocations

In response to the question, "*Do State agencies review how resources are allocated to better support access to inclusive programs?"* all respondents reported that to the best of their knowledge such a review does not take place or the plans to do so are in an embryonic stage of development. Further, respondents acknowledged that equally non-existent or in a nascent stage are plans for the *State Interagency Task Force and/or their state agencies' development of financial mapping plans to determine how to most efficiently and effectively utilize funds from different funding streams to support the participation of children with disabilities across the full range of early childhood programs.* However, two respondents reported an awareness of in process/ partially implemented MOUs that provide guidance or procedures to enable *State agencies to allow the braiding of funds across early childhood programs, when appropriate to support inclusion.*

Ensure Quality Rating Frameworks are Inclusive

Based on the findings of the Inclusion Self-Assessment, the Territory's Quality Rating and Improvement System (QRIS) does not *include early childhood programs beyond child care.* Respondents reported that policies and plans *for the QRIS framework indicators to address the learning and developmental needs of children with disabilities within each level of the framework,* and *offer incentives and supports to effectively provide inclusive program practices* are not currently available or they may be in the planning stage and not yet implemented. Further information about the Territory's ECE Quality Rating Improvement

System (QRIS), Virgin Islands Steps to Quality (VIS2Q), is documented in Section III. 7 of this Needs Assessment - Indicators of Progress.

Strengthen Accountability and Build Incentive Structures

The ratings were mixed for this section of the self-assessment survey and respondents provided little or no information as supporting evidence of the Territory's policy status as it pertains to strengthening accountability and building incentive structures in the ECE mixed delivery system. The majority of the participants, who responded to this item on the survey, reported that policies for *State agencies to incorporate inclusion indicators in their child care licensing standards and/or in agreements made with providers who offer subsidized placement options* have not yet been implemented in the Territory. This notwithstanding, nearly one-half of the respondents indicated that there are policies in process or fully implemented for the *State Education Agency (SEA) and Lead Agency (LA) for Early Intervention to require documentation from local programs for how Least Restrictive (LRE) and Natural Environments requirements are being met.*

Build a Coordinated Early Childhood Professional Development (PD) System

Several respondents reported that there is a partially or fully implemented policy which allows *agencies to have a common knowledge and competency base across early childhood, early intervention and early childhood special education programs so that personnel supporting young children have knowledge of child development and learning, including considerations for children with disabilities*. However, no evidence was provided to support the claim. The majority of respondents further indicated that the State agencies have partially or fully implemented policies to *ensure that personnel standards, certifications, credentials, licensure requirements, and workforce preparation programs for early childhood program personnel, including administrators, include competencies for supporting children with disabilities and their families.*

Interestingly, only one of the nine respondents reported that agencies in the Territory have, at a minimum, an in process and/ or partially implemented policy that allows for *partnership with institutions of higher education (IHEs) [such as the University of the Virgin Islands] to ensure that early childhood preparation degree programs include specific pedagogy for children with disabilities woven throughout the entire curriculum, including*

coursework and practicum experiences, rather than contained in a small number of supplemental courses or a separate program. However, most of the respondents indicated that *agencies offer on-site professional development and TA in evidence-based practices that support inclusion.*

Implement Statewide Supports for Children's Social-Emotional and Behavioral Health

In response to the question, "*Do early childhood programs have access to guidance to build capacity in working with young children, with an emphasis on fostering social-emotional and behavioral health such as the early childhood mental health?,"* the majority of the participants reported that access to such guidance is in process or fully implemented to support children's social-emotional and behavioral health.

Raise Public Awareness

A third of the respondents reported that there is a policy that speaks to the *State Interagency Task Force and its respective agencies having established partnerships with state and community leaders to communicate the benefits of early childhood inclusion that* is either fully or partially implemented. The majority of the respondents also indicated that, to the best of their knowledge, if *the State Interagency Task Force and its respective agencies affirm and communicate laws and research that provide the foundation for inclusion to key partners (e.g., families of children with and without disabilities, pediatric healthcare providers, businesses and private sector partners and other relevant community leaders);* and plans to *communicate their expectations to local communities that they are responsible for ensuring all children and their families have access to high-quality early childhood programs and the individualized supports they need to fully participate in these programs,* those plans are either not yet implemented or in the planning stage.

MDS System Strength and Gaps

Based on the findings of the State Early Childhood Inclusion Self-Assessment the USVI's ECE MDS is in compliance with the federal rules and requirements governing ECE programs. However, it is clear that there are gaps and, or delays, to include ensuring that data are used to generate baseline information and to track the progress of the number of children under five, with and without disabilities, toward increasing the number of children in high-quality early childhood programs. There are opportunities for the ECE policy makers in the

Territory to address some of the deficiencies revealed by the findings, for example, the chance to incorporate the learning and developmental needs of children with disabilities within each level of the framework, and offer incentives and supports to effectively provide inclusive program practices in the Virgin Islands Steps to Quality (VIS2Q) - Quality Rating Improvement System (QRIS). Other areas of the ECE MDS that are shown, from the findings, to require strengthening, include having fully implemented policies and guidance for a coordinated early childhood professional development system and targeting opportunities for increasing public awareness to communicate the benefits of early childhood inclusion to ensure all children and their families have access to high-quality early childhood programs and the individualized supports they need to fully participate in these programs.

Owners/Operators of Private Childcare Facilities and other Private Providers in the USVI ECE MDS

To ensure that the perspectives of the full range of stakeholders were reflected in the Needs Assessment, pediatricians and owners/operators of licensed private childcare facilities across the Territory were invited to participate in focus group (FG) discussions. Four such focus group discussions were conducted, telephonically with participants who serve the B-5 population and their families in both the St. Croix and St. Thomas-St. John Districts. Findings based on questions posed in five key areas follow, as well as other salient observations made by participants from these stakeholder groups. To ensure that key issues with respect to both healthcare considerations and early childhood education are appropriately represented, findings from focus group discussions with private healthcare providers are presented first followed by findings from focus group discussions with owners/operators of private childcare facilities.

Private Healthcare Providers Serving the B-5 Population

Healthcare providers from both the St. Croix and St. Thomas-St. John Districts participated in virtual focus group discussions. In response to a query regarding the length of time that they have been providing health care services in the Territory, focus group (FG) participants shared that they have been providing health care in the Territory for as short a time as 4.5 months to over 30 years. All providers who participated in the focus group discussions were female.

Children Served

Providers described the children served in their health care practices in terms of race, ethnicity, type of insurance used, as well as the primary language of children and families served. The majority (75%) of clients are Black, with the percent of White clients ranging from 5 – 15%. Though percentages were not provided, participants noted clients whose primary language was not English tended to be from the Dominican Republic or Haiti. A small proportion of all providers' clients are Hispanic. There were differences across providers with respect to type of insurance, with some noting that between 80 and 85% of clients are insured through Medicaid, with 10% on private insurance, and another noting that 50% of clients are self-pay and another 50% have private insurance.

Community's strength in responding to childcare needs

In responding to the question around the community's strengths in responding to childcare needs, FG respondents referenced the collaboration that exists among providers as well as informal partnerships with Head Start and MCH. Particular mention was made of the availability of a "top notch" Neonatal Intensive Care Unit (NICU), neonatologists, and pediatricians. Reliable newborn screening services were also referenced. The quotes below speak to these strengths more directly.

> *… the neonatologists are great, Dr. R is fantastic …, and the nurses there [JFL] are very good at the hospital for pediatrics. I think sometimes in the ER they aren't as comfortable with them, but I've never had them not do a good job. So, I think they have a good system for the newborn screening, and I think they have a good system for the hearing screening and for immunizations.* [FG, 3/10 & 12/2020]

> *… my agency and other agencies work collaboratively to give the care that we need, whether it's emotional care, or psychological care, or whether it's just medical and physical care. We also work with places like MCH if we have a patient that we share, or a service that they have an MCH where patients may need, we actually will share that patient. Not only do we share the patient, but depending on the chronicity of the illness, MCH becomes the major primary care for that particular patient. …And, in addition, we also work with the emergency room and if patients are admitted to the hospital, have consultation with the admitting pediatricians. So, we also have collaboration within the hospitals.* [FG, 3/10 & 12/2020]

Improvements that could positively impact early childcare in the USVI

Participants then shared their views on improvements that could be put in place to positively impact early childcare in the Territory. In this area, responses generally revolved around addressing needed specialty care for pediatric clients through an expansion of existing services. Existing specialty care was described as being constrained by scheduling, for

example, a neurologist that provides services once a month; another provider who offers specialty services quarterly, and, for children with developmental issues, referrals that are made to the Infant and Toddlers Program (Part C) housed within the VIDOH. The quotes below capture some of the points made around the improvement that could positively impact early childcare in the Territory.

> *…when I discharged a baby how do I know if anyone sees them? How do I know if anyone checks on their weight, if they're jaundice, if they're breastfeeding? Well, I don't know. I don't know who's going to follow up on the newborn screening. I only know the ones who come here.* [FG, 3/10 & 12/2020]

> "*…there is a lack of pediatric specialist care on the island. … that's a deficit …I'll be working with pediatric sickle cell…trying to identify a pediatric hematologist that can work with me. I had a little one today who's four, who was concerned about her asthma and I don't have a pediatric pulmonologist on island…* [FG, 3/10 & 12/2020]

> *…if someone is two days old, has jaundice, has breastfeeding, you know, whatever issue, if they go to the Health department, to be honest, I don't know who sees them"…There are a few with sickle cell, a few with CP seizure disorders, some pre-term babies. I had one child recently that has panhypopituitarism, so there's a lot of problems with availability of specialists on the islands, so for a lot of things people have to fly off island.* [FG, 3/10 & 12/2020]

Top health challenges for B-5 population and health challenges not being addressed

Top health challenges noted revolved primarily around respiratory illnesses to include respiratory viruses, asthma, upper respiratory illnesses, influenza, and allergy problems. Other health challenges noted were vomiting, diarrhea, and jaundice. With respect to respiratory illnesses, one provider noted: *In comparison to Washington DC, I've seen more asthma and allergy problems in the Virgin Islands.*

Agreements in place to address ECE needs and agreements still needed

While one provider noted an agreement with the MAP program through the MCH & CSHCN Program, others acknowledged informal partnerships, but no formal agreements in place. The quotes below capture descriptions of agreements in place between providers and other entities.

> *We have agreements with Medical Assistant [Program MAP]. If we don't have the specialists here on island, we're able to send out the patients off island. I think it's not as good as it could be. I think it's the number of patients that are referred, and the understaff [sic] and maybe Human Services, where our patients who need to go off island are not serviced as fast as we'd like for them to be serviced.* [FG, 3/10 & 12/2020]

> *We don't have any formal agreements in place. The times that I've had to refer patients, it's been an informal discussion with like Nicholas Children's in Miami with finding the*

appropriate specialists. So yeah, it's more of an informal way that we look for those sub specialists. [FG, 3/10 & 12/2020]

Other salient observations

When given the opportunity to provide additional feedback beyond the questions posed, health care providers participating in focus group discussions referenced the existing home visiting program in place for young mothers as a positive opportunity and service for expectant mothers, but also noted infrastructure challenges that still exist for healthcare facilities in the aftermath of Hurricanes Irma and Maria (September 2017). Additionally, the need to pay attention to obesity in young children was also mentioned. The quotes below capture some of the salient observations made by FG participants.

> *…there is some home visitation thing that my patient whose child gets shots of the Health department, they approached her,… and she's really enjoyed having them come. Her baby is six months from now… it's helpful for young mothers. And probably, even though she was not really a high-risk person, probably support for teenage mothers will be good.* [FG, 3/10 & 12/2020]

> *We have a lot of patients who are much older, of course, but even some of our kids between zero to five are overweight. Most of our kids, usually elementary to adolescence are really overweight children, and a lot of that has to do with social media and the devices that they use.* [FG, 3/10 & 12/2020]

> *Because the hospital has lost so many rooms because of mold or whatever, there are only actually two available rooms for a maximum of four inpatients for the hospital for pediatrics, so they can have, depending on the gender, the age, and the diagnosis, only two to four people admitted for pediatrics. And so, they need a new hospital here.* [FG, 3/10 & 12/2020]

Owners/Operators of Licensed, Private Childcare Facilities

The owners/operators of licensed, private childcare facilities who participated in the two focus group discussions were all female and have been providing services to children for a number of years, ranging from four (4) to 38, with a median number of years in the field of 20. Participants reflect both the St. Croix and St. Thomas-St. John Districts.

Children Served

Focus group participants shared that they serve a diverse group of children who are between the ages of birth to five years of age and are primarily Black, English-speaking, low income or disadvantaged children. One childcare provider represented a facility that spans preschool through senior high school. For one provider, the tuition of 95% of the children

served is supported through Block Grant funds, while, for another, though noting that most families would not qualify for Block Grant support, noted that 90% of families receive financial aid and pay "scaled-down" tuition. One provider also noted have a "large number of Dominican Republic, non-English speaking" children as well as Arabic, non-English speaking children/families. With the exception of one provider, all others noted having Hispanic children at their facilities.

Community's strength in responding to childcare and education needs

In addressing the community's strength in responding to childcare and education needs, FG participants focused the availability of early childcare and the value of these experiences in exposing children to their first, organized learning experience, and supporting them with their language development as well as social and emotional development and motor skills. Other skills referenced as being developed through the ECE experience included communication and socialization skills as well as fine motor skills. The quotes below highlight some of the points made by participants.

> *I think it's the contact with the parents and our commitment to them as this is the school, them and the child. It's a three-pronged thing for their education. They know that we feel that children learn through play, so there's a lot of play that goes on in the course of a day, but we also follow a lot of the creative curriculum. So, we're looking at the social, emotional development, motor skills, all that kind of stuff. But a lot of it the kids don't even know it's a lesson; they feel like it's play.* [FG, 3/11 & 13/2020]

> *Well its (preschool) one that's necessary to see growth. Once children get into kindergarten, I think it's the ideal bridge to ensure that learning takes place. … I think the work that we do is essential, and it's indeed a stepping stone to move forward.* [FG, 3/11 & 13/2020]

Improvements that could positively impact early childcare in the USVI

Three major areas dominated responses regarding improvements that could positively impact early childcare in the Territory: more support for private childcare facilities from VIDHS, to include subsidies for teachers and funding to retain qualified teachers and purchase equipment; more staff training and more support for teacher training; and more parent workshops and increased parental involvement. Two particularly poignant quotes are provided that capture the points made by participants with respect to improvements to positively impact early childcare in the Territory.

More assistance from Human Services. They [DHS] heavily regulate the centers, but I think … They once mentioned that they would also try to give like a subsidy for teachers. Because, what's happening is once a teacher or preschool teacher gets enough credit, they want you to have a CDA but most of them, once they're on that path, and let's say they get an AA. And with the pay that a small business can pay a preschool teacher, they more or less stay with you for a little while and they venture out to the Department of Ed, because that salary is much higher as a paraprofessional. So, it's very hard to maintain your staff. The turnaround is so high because we can't afford to pay more, but if Human Services – and they recognize that it's essential to have these bodies … who assist the children, give us a stipend that we can give. I mean, even if it goes directly to the teacher, then do that, but they require so much, but then they don't help us. You know, it's hard. I think every year it seems like a challenge. Should I go forward? … It's just a hard situation all around, but they demand a whole lot and I don't feel like they give good support. It's not only about regulation. It's about keeping us – being that assistance that we could rely on. [FG, 3/11 & 13/2020]

One of the things I definitely have to say is parental – like having workshops with these parents. And I think when we think about day care centers and then we talk about a school like [name redacted] is a big school, so for me, I feel as though (I'm probably just looking from the outside – I may be wrong,) they have a lot more support than we do as a small unit. And so, because I worked for Department of Education and I had all of these resources, sometimes I am able to reach out to people and ask different questions, but for others, they don't have that resource. And so, it's difficult for us to have that training that we would like for parents to have this understanding of what we really do in preschool, and what is really expected of your child. [FG, 3/11 & 13/2020]

How program serves non-English-speaking B-5 children and their families

There were a range of responses with respect to how programs serve non-English-speaking B-5 children and their families. Some providers noted that their programs currently did not have non-English-speaking children, while another indicated that staff members spoke basic Spanish, or that translators are available during parent conferences for non-English-speaking parents. Some participants indicated that materials and resources are available in English, Spanish, and Creole, while another shared that reports are made available to parents in their primary language(s). The quote that follows is representative of responses provided.

Well for us, for the language barrier, all of our materials are printed in Spanish, and some of them in Creole and that's a very small number, but all the reporting goes out in those languages. We have two people on staff that are there to translate for us in conferences, so any conference that we might need to have with the parent, there's another person who can translate the language so we're all on the same page. [FG, 3/11 & 13/2020]

How programs accommodate children with disabilities

With respect to supporting children with disabilities or special needs, participants shared the need to engage assistance from VIDE, an outside therapist, or the support of a private company contracted to specifically assist with children with disabilities. Some participants also noted efforts to address physical disabilities by having ramps at their facilities, working closely with teachers to provide needed support, while also acknowledging that there are limitations in terms of the number of children with disabilities that can be accommodated by the childcare facility based on the lack of qualified staff to provide the appropriate supports to these children. The quotes that follow are reflective of the responses shared.

> *… so all of ours now speak English, so we have no issues with that but we do have students with disabilities. The only way we're able to assist is because we have an independent company that comes in. Well, it's a two-fold. Some of them come from the Department of Ed where they give that additional services with the students, and then we have a private company who also parents sign up through them to come to the center to give the additional services. They're in part, they merge with us and let us know what we should be doing to better assist the students. That's how that's being done.* [FG, 3/11 & 13/2020]

> *We do have some kids with disabilities and have had some kids with autism. We work with the teachers really closely, try to get as much of a support group for kids with disabilities. The earlier kids with disabilities begin their education, the better it's going to be. So, sometimes it's convincing having conversations with parents about what kind of needs their kids are going to have during their education. It's really important to get that across so you can proceed, and a lot of people are very afraid if their children are different.* [FG, 3/11 & 13/2020]

> *… even though you have students who require a little more with the services we give, we don't discriminate with our children, they're not being charged additional because they need additional help, but what we have explained to Human Services is, once you have children with disabilities or learning deficiencies, sometimes you have to, in turn as the establishment, hire additional help to assist that teacher, because if you have a child that constantly is disruptive, can't control his or herself because of what disability they're going through, you have to have another body there to assist. But I don't think they even take those stuff into consideration when it comes again, time for us to pay to have sufficient coverage for our centers. I just wanted to put that in, but we don't discriminate. We love all children that come, and all children require and will get the same just treatment.* [FG, 3/11 & 13/2020]

Strategies to engage parents

A major area of focus was around engaging parents within the childcare facilities. Responses varied with respect to strategies that various facilities utilize to engage parents and to sustain that parental engagement. Several participants shared their use of strategies that

involve engaging parents around specific activities, special occasions, or themed events, for example, holiday celebrations, “activity nights”, and observances of special days. Participants also mentioned keeping parents abreast of what is happening by sharing a calendar of events, holding regular assemblies, or utilizing a text messaging system to keep parents informed in “real time”. While some participants noted that some parents are “excited and responsive” and even “initiate involvement”, there was also an acknowledgement that some parents are so busy working, or seem to have such demanding schedules, that securing the level of parental engagement needed is an ongoing challenge. The quotes that follow a representative of the perspectives shared by participants.

> *Oh. I think, at this age group, parents are excited. So, to me it's not even a challenge to get them engaged. In the beginning we were like well we do most of our classwork within school, so that they don't have too much because we close like 5:30 every day, but parents are asking for sheets so they can do worksheets at home in the evening. So, I think the involvement is so strong at the early ages. We could call them in saying we need readers to come in to show the value of reading. Especially, March is Dr. Seuss month, so you can get them to come in; People take off time to be there. So, I don't think it's hard at this age group, but I don't know if something happens once they go into elementary because moving forward, it just drops off a little. I don't know if it's the excitement to hear them read as they start, but parents are involved. We could get parents to do everything at this age, I think.* [FG, 3/11 & 13/2020]

> *We use this system called Dojo. It's like text messaging system that all the teachers, including the early childhood teachers use to send pictures throughout the day of their children in different activities. It can be done on a group platform where you get every parent in that group looking at pictures and activities, and then it can also be just to the individual person, like if their child is having a difficult day, it's very easy for them to go through Dojo and let the parents know right away what kind of day it's been.* [FG, 3/11 & 13/2020]

> *Sometimes, and it's kind of difficult on my end because how to get the parents involved sometimes takes a little toll because they're so busy at work they can't take off, you know, but what I usually do, I use the holidays at times to engage. I invite the parents, you know, have a little hands on eating, then we sit down, socialize. So, my way of doing that is I wait up to till there's like some function or birthday party, and that's when they get together. I have them stay a little bit by having finger foods, I inform them ever so often what we're doing, have the kids color, have them go home, ask them to bring in a little stuff just to participate a little bit and just get their feedback when they come in. But with my parents, everybody seems to be on the go, they don’t have time to come in, so I'm trying my best and I’m trying something new just to try to get them involved.* [FG, 3/11 & 13/2020]

> *From my school, we do a couple things. So, we do have a lot of moments where our parents are engaged in activity nights. And to be honest with you we pick random nights so sometimes it might be math, sometimes it might be arts and craft, sometimes it might be music because they*

just feel like music is music, but I think one moment where we had the students sing the songs from Pressure, the parents were actually surprised that the kids knew the words, but they also knew what the VI sign was and it was just a part of culture that they were surprised that their kids were really involved in it…" So, we just involve them in everything. We have a Christmas and Thanksgiving eat with your family sit down. This year for the first time, we actually did a Valentine's family eat out. We had so many people, our building was packed so they weren't able to enjoy the food that the kids eat on a daily basis. [FG, 3/11 & 13/2020]

Unmet needs of B-5 children and their families in Territory's ECE MDS

Interestingly, some participants did not identify or indicate that there were any unmet needs for the B-5 population and their families, with respect to the Territory's ECE MDS. However, for the participants who noted unmet needs, the needs all revolved around the area of behavioral health, to include children with severe emotional needs and families in crisis, and care for children with special needs such as autism. The quote below is a poignant reflection of the description of one of these gaps.

We had an autistic student that was non-verbal and was very aggressive and we couldn't help that parent, and it was sad to turn to her and say, I do apologize but we can't help you because we don't really have enough services to help you. [FG, 3/11 & 13/2020]

Other salient observations

As the FG discussion ended, participants were asked to share final thoughts that may not have been addressed through the specific questions posed, with a view to strengthening the Territory's ECE MDS. Interestingly, the responses revolved around the need for additional support from VIDHS for private licensed childcare facilities, expanded availability of and access to professional development for caregivers in private childcare settings, as well as better communication between public and private caregivers and leaders with respect to expectations for Kindergarten readiness. The quotes that follow are representative of the thoughts shared by participants.

…I think we can do a lot more here if, like she said, Human Services give us some help and staff is a major, major issue. That is our biggest issue. It's a major issue here. Even if I'm trying to contact Human Services trying to see if I can get some help, they have no… , I think there is a service you can get help, she said there's no one there available to childcare. Right now, I'm doing my CDA, and I expressed my to my teacher at class that, everything said and done, I am so into it, but the problem is staffing. It's so hard, it takes a toll on us here. I feel like I'm overworking the little staff that I have because it's just rough, but I would like to see more involvement as far as human services having activities, engaging a lot more for the kids. I think after the hurricanes we had… we have been doing some stuff before then, but everything seems to have diminished a little bit. We don't have it as much and getting help as she said. That's all

we need, help. I think that if we can get the help that we need, things will go so much better. [FG, 3/11 & 13/2020]

Just for Human Services to be more supportive and they have mentioned about helping the schools run efficiently by assisting us with stipends for our staff so that we don't have that high turnover. Everyone seems to recognize that early childhood education is very important, but I don't think they look at how they can help small businesses ensure that because it is very challenging. [FG, 3/11 & 13/2020]

…the University, even if they do once a semester, course that child care person could come and take as credit hours of that nature, just to show the importance of what we're doing and the value that centers showing that we're valued for the services we render. [FG, 3/11 & 13/2020]

If there's a way where we could actually have a lot more updated training, and when I say updated, I just mean, every year there are things that are brand new. Like you were talking about the national standards. Some people, you know, they may have never heard of that before, and just to kind of keep everyone updated on the same page, that we are all getting our kids ready for that big step in going into kindergarten and moving on, that we are all up to date on what we're supposed to be providing for our students. [FG, 3/11 & 13/2020]

The focus group discussions with healthcare providers and owners/operators of childcare facilities provided opportunities to hear directly from these stakeholders and to understand how they support the B-5 population; gaps that currently exist in the Territory's ECE MDS; how they work with providers and policymakers in the public sector, and how the Territory's ECE MDS can be strengthened and improved to ensure better outcomes for the Territory's B-5 population.

Community Voices – Town Hall Meetings

Project personnel also sought input from the broader community through participation in town hall meetings scheduled across the islands of St. John, St. Croix, and St. Thomas. A total of five Town Hall (TH) meetings were held and participants ranged from current and former owners/operators/directors of licensed childcare facilities, to current and former public education and health administrators, to legislators, private school administrators, to former government policy-makers, to members of the general public. The first Town Hall meeting was held at the end of September 2019 and the remaining four were held over the course of the first three days of October, with one team on St. Croix and the other team on St. Thomas.

It should be noted that though the Town Hall meetings were publicized through radio, print, and electronic media, very few attendees had children in the targeted B-5 age group. Yet, the information garnered from the Town Hall meetings helped to supplement other findings reported in the Needs Assessment. Findings based on questions posed in five key areas follow, as well as other salient observations made by participants who attended the Town Hall meetings.

Experiences with healthcare system; availability/accessing services for children B-5; & rating of the healthcare system [for children B-5]

Town Hall meeting participants shared a range of experiences with the Territory's healthcare system with respect to availability, accessibility, and overall rating of quality of the system of care for the children, ages B-5. While generally, participants shared being satisfied with the availability, accessibility and quality of the Territory's healthcare system, there were some poignant examples of geographic disparities, particularly with respect to the availability and accessibility of healthcare services, to include issues ranging from accessing specialty care and timeliness of getting appointments, to challenges with care for children with special needs.

Participants' rating of the current healthcare system, with respect to meeting the needs of the B-5 population, reflected some "unpacking" of aspects of healthcare, for example, distinguishing between considerations of medical care only, to factoring in behavioral health care and even dental care. Ratings, on a scale of 1 to 10, with "1" being "best", ranged from a high of "1" to a low of "7 or 8", with most ratings hovering in the 3, 4, or 5 range. Some representative quotes are provided below that capture the range of sentiments expressed.

> *… my children got the same benefits of the doctor that served me as a child, so I thought continuity of care was awesome.* [TH, 10/2019]
>
> *The most complaints I get right now from the parents of the students are they're usually quite booked up at the East End Clinic. Because I know even with my own daughter when the appointments are so far, I've just opted to do the walk-in versus the wait for the scheduled appointment because it's usually three, four months away.* [TH, 10/2019]
>
> *You just have to commit a few hours, even if you go in there and you sign in 6:00, 6:30, but it works. You go in and you sign in between 6:00 and 6:30. If they feel the need to tell you, well, we could see you around 1:00, leave and come back, they'll tell you that. So I can appreciate that.* [TH, 10/2019]

I think that's a big problem because even – sometimes the screenings – they are all on St. Thomas. I mean it may sound simple, but for you to – you have to pay a boat and pay a taxi and then take your child in to town. [TH, 09/2019]

… but sometimes it's like so many services get taken away from the island…. It looked like only one person was doing immunization. So I ended up having to go to St. Thomas to get the immunization done. Now I will do that because I was fortunate to be a government employee. So I had insurance and my kids were on my insurance, but the average person would say if I have to go to St. Thomas, I'm not going, you know. So sometimes things like that happen. And it's not like all the time, but sometimes you have just limited access because it was just one person doing this here and that person ain't [sic] around. [TH, 09/2019]

… if you talk to professionals on this island, many of them have a preference with respect to a pediatrician. The first thing out of their mouth is Dr. R, that's amongst the professionals. That's where we take our kids for runny noses, any malady…. But professionally, I come from an alternative education perspective – and even though they're not infants or Pre-K students, those older children have younger siblings. And one of the things that's very disappointing … is that many of them get no neonatal care; the mothers – they get no infant care…. Many of those children their first encounter with medical assistance is at the emergency room; not at a pediatrician where they can get preventive care. [TH, 10/2019]

But we had to do the immunizations, and that was a trip…. But that – it wasn't bad; it wasn't a difficult thing to do. It was just you had to go from one place to the other I was used to, once you have your shot record rom the pediatrician that would suffice. But here it doesn't work that way. You have to go and get everything on to one record, so that was a difference for me. … And, as of right now, they go to a private physician. But, like you, recently, the under 2-year old had to catch up on his immunizations at the Department of Health. [TH, 10/2019]

… sometimes the parents have problems with – they don't have a care and so forth, a nd you tell me you're coming to pick me up; that you're going to take me and then you don't show up, and that's a day missed and so forth. So, that does be the problem sometimes. [TH, 10/2019]

Several persons who attended one of the five TH meetings provided explanations for the ratings given regarding their experiences (or those of family members) with the healthcare system, within the context of care for the B-5 population. Some representative quotes follow.

2 – 1 – emergencies, included, and then with this little one that we're dealing with that grandma is going through the system, just how much follow-up care. 'Cause like he has follow-up coming up this week with scans and then he goes back for the doctor to be able to give the results of the scans and what not. So, 2 – 1, good, for little people. [TH, 10/2019]

… it seems to work. … you know typically not just for healthcare, but even for little ones who might need some counseling services, that, you know, I happened to go to Island Therapy, I mean they really work … to get them an appointment … So, I overall will give it a 2, only because, you know, I'm aware there are certain services that are not available at all, you know, for the little ones that could be. [TH, 10/2019]

Well, for us, I would say it was a 1, you know. When my daughter was birth through five, she got regular immunizations; she got checkups annually. Her mother and grandmother every year, twice a year … would go to Pavia…. So, availability on island and certainly off island was not an issue for us. [TH, 10/2019]

I wouldn't put it above 5…. It's not completely bad. Well, if anything, 4, but not 1. [TH, 10/2019]

I think I'd say 5. Right in the middle…. Because there are – this may not be here or there right now, but more and more I see children who I think require – would need screening and, you know, we don't have access or parents may not have access to that kind of health without going to St. Thomas and paying privately for it. [TH, 09/2019]

Yeah, I tend to agree – like a 5…. Because we could just run to the clinic, you know, and – or if you choose to go to one of the private places on the island. But, as far as emotional health, I don't know where. The only thing – you might get it here is if you are in the schools and you get referred. Then, you know, you get some kind of services. But as far as having somebody on St. John, I think you might have to go to St. Thomas. I think it's Insight. Insight. At one point I know they use to come and do something on St. John. But if that is going on still, I don't know. [TH, 09/2019]

It's a 2. I worked for the hospital for five years, so I know the challenges the hospital has. I know when like the Ambulatory Care Center opened up behind the hospital where you can walk into the Ambulatory Care Center and take your child in there for whatever the situation might be, be seen within an hour and a half. [TH, 09/2019]

Best experiences & greatest challenges for your children's time in preschool/HS/EHS/daycare

With respect to best experiences their children had during their preschool years, a vast majority of responses revolved around the level of school readiness children had when they entered the K-12 school system and the development of social skills. Challenges experienced had a wider range and included responses around cost of care; lack of sufficient space in some early care settings; lack of the availability of programs; and challenges securing care or limited/inadequate services for children with special needs. Some representative quotes related to best experiences and greatest challenges follow.

With respect to best experiences, Town Hall participants shared the following:

… I think my children got a very good start for Kindergarten. By the time they got to Kindergarten, they were actually ready to be in Kindergarten. [TH, 09/2019]

I feel that my children had a wonderful experience in preschool but -- it was offered through my church. I was completely pleased so much so that when they started in the parochial school they were ahead. As far as your expectation from the teachers, they were ahead. [TH, 10/2019]

The – the willingness, the eagerness they had to go to school. Which, the report that I had read way before that said that once these children start early, they are always eager. They are eager to learn; they're eager to get in there, and I saw this. [TH, 10/2019]

My daughter actually started at K-4 in Montessori at Manor School. And having come from Catholic School where there is this very rigorous structure, I was a bit leery, because I did some investigation, and I'm like, there's no way my child is going to Manor School to Montessori. All she's going to do is play, play, play…. But it was a good experience for her, because it was learning through play. And I think it actually prepared her much better for the rigor of St. Mary's. [TH, 10/2019]

My daughters … went to Good Hope. And there was some academic, but it was a lot of letting children be children. You had a sandbox; you had a, you know, pretend play, you know, in those things. And kids learned a lot of socialization behaviors in those kinds of things…. I think socialization is really important. And what some people call 'readiness,' you know, singling the A-B-C and blah, blah, blah, is not readiness to me, you know. It's being able to get along with other children in a setting realizing that you're not the only one who needs the attention – [TH, 10/2019]

With respect to challenges, two statements that stood out relate to the availability of programs and services.

One of the things that I always heard some parents talk about is the lack of services for children that are autistic…. I know some parents were like so frustrated trying to find these types of services from early, you know, and they didn't want their kids to be tossed into some group and set aside and not get exposure like other kids. [TH, 10/2019]

I also think that there's a problem here with the programs, not enough programs in the Virgin Islands for the amount of children they have to serve. So you might have also the availability of Block Grants for our children that need the Block Grant. There's a waiting list. So, therefore, the children, those young babies … that's why sometimes they're home with their parents because they have to go on a waiting list for a Block Grant. [TH, 10/2019]

Parental Engagement

With respect to engaging parents, there was a wide range of perspectives, to include keeping parents in the loop and scheduling regular meetings to discuss their children's progress. There was also an acknowledgement that parents need to be provided with resources that they could use with their children. Additionally, some participants suggested engaging parents by inviting them to participate in special activities at their children's childcare facilities. While there was some discussion of the need to mandate some degree of parental participation and the need to "levy sanctions for non-participation", there was also discussion of avoiding "draconian" approaches to get parents to participate as those could have the effect of turning parents away, rather than engendering parental engagement. A variety of ideas

were shared with respect to engaging parents. Some representative quotes that capture some of these ideas are presented below.

> *Sometimes meetings are helpful. I mean, you know, meetings that have activities that include an actual interactive activity. 'Cause like kids, adults, we learn when we do things too.* [TH, 10/2019]
>
> *Like having parents come in to do stories…. Or, you know a clean-up day at school, you know, those types of things, just interact with things that bring the child and the parent together.* [TH, 10/2019]
>
> *… have the kids have their parents come to events…. Social kinds of things at the school, you know. And also scheduling, I mean, you know, find out what – when can parents come, you know.* [TH, 10/2019]
>
> *There is an assumption that the solution isn't the same for every parent….I just need engagement. So the engagement doesn't have to look the same because it does have to be varied for our parents to be successful. It has to look different and it has to be personalized, so to speak. So I accept that. I accept that. But it cannot exclude them is my position. It has to include them. And that's where I think many of us are failing…. I don't have a problem meeting you there, meeting you half way, but it has to include you.* [TH, 10/2019]
>
> *We invite – like in my contract or in an additional letter, I state that parents are welcomed to come at any time to share any extra things that they might be able to do. I had one grandpa who kept bees, and he came in. And he talked to the children about the bees and how they make the honey. And they were able to sample the honey and so on.* [TH, 09/2019]
>
> *A lot of Open Houses. Invite the parents to come in, make it a part of your contract when you sign the child up to attend that particular daycare. As part of you taking care of the child every day, the parent now gives back by coming. You're not asking them for anything except for them to come and maybe see what you do during the daytime, but within an hour.* [TH, 09/2019]
>
> *If you have, like, a one-stop shop every summer or before registration or whatever where you have healthcare, you have Human Services providers, everybody under one tent and families can come, go through the process; see what is available; have their children screened or set up appointments for them. But there should be an avenue so that parent can have a way to see what's available, you know, and under one roof.* [TH, 10/2019]

Changes to make ECE facilities more effective

Asked for their perspectives on changes that could be made to increase the effectiveness of ECE facilities in the Territory, there were some common threads in responses provided by participants across the five Town Hall meetings. Responses centered on initial preparation, as well as ongoing professional development and coaching for ECE caregivers. Additionally, several participants mentioned the need for increased support or private

childcare facilities by VIDHS as well as for more and stronger public-private collaboration to improve overall ECE programs and services in the Territory. Participants also addressed the need for financial support for private childcare facilities. The quotes below capture the essence of some of the thoughts shared by participants.

> *… And when a center is starting, they actually need to get a coaching. They need to get guidance in setting up. But you see, money is one of the problems. Because if you don't have the funds, you cannot set up your center and you cannot get the type of materials and supplies that you need to actually have a different thing introduced to your center every week so that the interest remains, you know, with the kinds so that they're stimulated…. So funds, one of the things, support one of the other things that we need, and the training. And really, really push CDA as opposed to even a Bachelor's.* [TH, 10/2019]

> *I would like to see more access to professional development opportunities. When I left Human Services … we were supposed to launch the QRIS, which is the Quality Rating Improvement System. And, for the life of me, we couldn't get to do that, because we didn't have a lot of things; number one, a Professional Development Registry.* [TH, 10/2019]

> *I would expand on that from the professional development to expanding opportunities for parents, education-wise, on how to take care of little ones.* [TH, 10/2019]

> *Well, I'm having like a moment right now because … we just came together right, to do this. We had a parent survey on Monday and that was the result—that was a huge thing. I was like 'Oh, my gosh; this is crazy; I didn't expect to see this.' In the Pre-K population what parents are saying as a result of this survey is that for the Pre-K group and for the early childhood group, they feel like we are lacking in professional development, and parent conferences, yeah parent information …* [TH, 10/2019]

> *I think too many a times we see that the Government doesn't have the capacity to – sometimes there might be the capacity to start something really good. But then long-term implementation and sustainability become a problem. And so I feel if we try to explore ways beyond the Government that we could talk about sustainability and longevity of a lot of the programs, I think that – might be like the first place to start. I'm just thinking about public/private partnerships and just bolstering the private sector, entities that want to do this good work.* [TH, 09/2019]

Other salient observations

To close out the Town Hall meetings, participants were given an opportunity to share final thoughts or observations around early childhood care and education in the Territory. Some of the thoughts shared centered around finding ways to better support parents and their ability to access needed services, especially with respect to securing immunizations timely, supporting children with special needs, and being more proactive about getting the message

across relative to the importance of early childhood education. The three quotes below are illustrative of these perspectives.

> *I think the Department of Health could do a little better in terms of immunizations….So I think they need to have some kind of service …then you would be able to bring your kids and have that done before they leave or they travel. So two weeks, three weeks before school and do it because it lasts a year. So that could be done so that it would be easier on the parents and then the registration for school would flow easier.* [TH, 10/2019]
>
> *I think that there needs to be a public awareness campaign to promote why early childhood education is so important.* [TH, 10/2019]
>
> *… I think the more children who could have access to early childhood education opportunities, the better it will be, I think for the people and for the community. … I really think it's crucial. And it can come in various ways. It can come in Montessori; it can come at home; … we've got to find ways to reduce those adverse experiences; limit exposure to too much negative experiences and promote the positives that early education provides.* [TH, 10/2019]

Participants at the Town Hall meetings reflected a wide range of stakeholders within the Territory's ECE MDS. Participants with children in the B-5 age groups represented the minority of participants. Other participants included current or retired educators, current owners/operators of childcare centers, administrators in educational settings with preschool programs, elected officials in the fields of health and education, employees from the legislative branch of government, and members of the university community. Despite the diversity of participants, the information shared confirms the need for expanded communication and communication strategies to more effectively support and engage parents/guardians of children B-5; increased and more targeted coordination with respect to the delivery of programs and services, and increased professional development for caregivers in childcare settings.

CHAPTER IV: SUMMARY AND DISCUSSION

This chapter provides a summary of key findings provided in the Needs Assessment and briefly discusses what the findings mean for efforts moving forward across the range of stakeholders, to strengthen the Territory's ECE MDS. A stronger ECE MDS for the Territory requires a commitment to increase access and availability of high quality programs, services, and providers; to inform and engage parents and guardians; to increase collaboration and coordination of programs and services; to engage strategic approaches to funding; and to engage in continuous quality improvement to ensure optimal outcomes for B-5 children supported through the Territory's ECE MDS. The summary is organized around the seven anticipated outcomes for the Needs Assessment. Within the context of strengthening the Territory's ECE MDS, it is important that funders, policymakers, and service providers understand the Territory's context as well as current needs in the Territory's ECE MDS as work continues on the Road to Success for the Territory's B-5 population, and particularly, the most vulnerable in this population.

SUMMARY

The B-5 population in the USVI

According to the 2015 VICS, the Territory's B-4 population represents approximately 5% of the Territory's overall population, and approximately 4% of the Territory's female population and approximately 6% of the Territory's male population. Using Kindergarten enrollment for the SY2014-2015 as a proxy for the number of children across the Territory who were five years old in 2015, it is estimated that the total number of children B-5 in the Territory in 2015 was 6,705, or 6.7% of the Territory's population for 2015 (the most recent year for which VICS data are available). Further, 2015 VICS data revealed that while 26% of the families living below the poverty level had children under six years of age residing in the households, 86% of these families were headed by single females. The vulnerability of the B-5 population in the USVI was also observed with respect to insurance status, with 60% of children B-4 insured through Medicaid, and 13% of children B-5 being uninsured.

Current ECE programs and services

Across the Territory, ECE programs are administered under the auspices of VIDHS, VIDOH, and VIDE, as well as through LSSVI, which administers EHS in the St. Croix District.

VIDHS administers HS and is also the entity that administers the CCDF program, through which, qualified families receive subsidies for childcare services. VIDHS also supports eligible families through the SNAP program and by assisting eligible parents with employment experience through the TANF program. In support of access to health care, B-5 children who qualify are insured through Medicaid and receive financial support for primary as well as specialty care, whether on island or outside the Territory. VIDOH administers the Infant and Toddlers Program (Part C), MCH & CHSCN Program, to include the MIECHV Program and the WIC Program.

The VIDE administers Part B, working with VIDOH to develop IEPs or IFSPs for children who are identified as needing special education supports once they reach the age of three. Toddlers, so identified, receive services through VIDE's District Offices of Special Education, whether children are enrolled in parochial, private, or public ECE facilities. Once children transition to Kindergarten in the VIDE K-12 system, kindergarteners needing substantial special education supports are placed in either therapeutic or transitional Kindergarten classrooms. Dual language learners (DLLs) are supported in ESL classes with bilingual staff who serve as primary caregivers or support for primary caregivers.

ECE programs and services are also offered through over 100 private and parochial childcare facilities (including those that provide after school and summer programs) that are licensed by VIDHS. These facilities are required to meet specific standards with respect to general administration; general qualifications of staff and directors; health rules and regulations; fire, building, and safety codes; staff, program, and facilities; and food service and nutrition. Licensed facilities are eligible for childcare subsidies as are eligible individuals who provide childcare services in their homes – family, friends, and neighbors (FFNs).

Curriculum and assessment systems: USVI ECE MDS

The USVI Head Start (HS) Program and the USVI Early Head Start (EHS) Program utilizes the HighScope Preschool Curriculum (HSPC) and the HighScope Infant-Toddler Curriculum (HSIC), respectively. Both curricula are aligned with the Early Learning Outcomes Framework, revised by ACF in 2015. EHS utilizes the Ages and Stages assessment to track toddlers' progress, beginning at 6-months and at regular intervals beyond, in accordance with targeted points at which assessments are to be conducted. HS utilizes the COR, which is

administered three times during the school year, once in late fall, early spring, and late spring. In addition to the COR, working collaboratively with VIDE, HS administers the LAP-3 to HS children in the spring before they are scheduled to transition to Kindergarten. While COR data were provided by HS personnel, Ages and Stages data were not readily accessible. LAP-3 data were available for children who had entered Kindergarten.

There was no identifiable repository of information available for private/parochial childcare centers relative to curriculum and assessment systems, though private licensed facilities must have written documentation on file regarding program activities for the children that they serve. Though private and parochial childcare centers are licensed by VIDHS, there are no requirements for reports that speak to the areas of curriculum and assessment systems utilized in the licensed facilities or information similar to the annual PIR that the HS and EHS programs are required to submit.

Gaps and barriers in USVI ECE programs and services

One of the most pervasive gaps evidenced is the absence of a repository of unduplicated ECE data that captures information for children B-5 across the Territory. Though the Territory has received funding to establish the Virgin Islands Virtual Information System (VIVIS), which also includes the Early Childhood Integrated Data System (ECIDS) under the larger VIVIS umbrella, data are currently not readily available as data sharing agreements are not in place and current data are not updated in “real time”. Additionally, to date, private licensed childcare facilities have not been identified for inclusion in ECIDS or VIVIS, though, as previously noted, there is no local PIR-like reporting requirements for private licensed childcare facilities. As work continues to address this data repository gap, the opportunity also exists to determine how best to integrate key indicators from licensed, private facilities so that there is a true picture of the children being served through the Territory’s ECE MDS.

Additionally, population level data, updated through the Virgin Islands Community Survey (VICS), are dated, with the most recent VICS, published in 2018, reflecting data for calendar year 2015. Further, funding data were not always disaggregated, thus actual funding levels could only be estimated. Other gap areas include a lack of an existing repository of collaborations across providers and agencies who offer ECE programs and services, with many agencies reporting only informal agreements.

In the area of quality of programs, gaps were noted as the Territory's ECE Quality Rating Improvement System (QRIS), Virgin Islands Steps to Quality (VIS2Q) is still in an embryonic stage, although piloting occurred in SY2016-2017, full implementation has not occurred. Further, results of the teacher survey, with a focus on caregivers' knowledge and beliefs about language and literacy development, demonstrated knowledge gaps that could have implications for the delivery of instruction in these areas in ECE settings.

Two other gap areas that were noted related to the capacity of the HS program in the St. Thomas-St. John District, which has lost three centers, two on the island of St. Thomas and one on the island of St. John, due to Hurricanes Irma and Maria. Finally, based on primary data collected from various stakeholders, there is a gap with respect to explicit policies in support of the Territory's ECE MDS and the communication and dissemination of these policies across providers at all levels – leaders/managers and caregivers. This gap in policies was particularly evident in responses to the Transition Survey, which revealed that though persons who responded were selected because of their role in the transition process, there was evidence of significant policy gaps and supports in this area.

Quality of USVI ECE programs and services

While the Territory's ECE QRIS, VIS2Q, has not yet been fully implemented, other indicators of quality were noted with respect to the Territory's ECE MDS. One such indicator is teacher qualifications. While the data on credentials for HS and EHS teachers and assistant teachers revealed that all met minimum credential criteria – at least an AA degree for HS teachers and a CDA for assistant teachers, the teacher survey data revealed that 29% of caregivers/teachers who responded to the caregiver survey did not hold a CDA. Another indicator of quality is the curriculum being used and, as previously noted, both HS and EHS programs in the Territory utilize the HighScope, which are research-based curricula. The licensing of ECE facilities also serves as a proxy for quality, as all licensed facilities must meet certain criteria that are related to overall quality indicators.

Perceptions of parents/guardians whose children attend USVI ECE programs

Overall, parents who responded to the survey, Quality from a Parent's Point of View, provided very positive feedback on the care that their children receive across the ECE MDS.

Parent participants represented the spectrum of ECE facilities – HS, EHS, as well as licensed private and parochial childcare facilities.

Funding available for existing USVI ECE programs and services

Most of the funding available for existing ECE programs and services in the Territory is provided through the Department of Health and Human Services (DHHS), the U.S. Department of Education (ED), or the U.S. Department of Agriculture (USDA). Local funding, in the form of matches, are required for the HS, EHS, and TANF programs. DHHS supports HS, EHS, MCH & CSHCN, and TANF. ED supports Part C, Part B, and supplemental instruction programs (Title V). The USDA supports WIC, SNAP, and the National School Lunch and School Breakfast programs –which support vulnerable children, B-5 in the Territory.

DISCUSSION

This Needs Assessment provides comprehensive documentation of the Territory's ECE MDS. The document describes the vulnerable and underserved children in the Territory, as well as information on those receiving services and numbers on waiting lists for services. The document also speaks to gaps in data, not only to support collaboration, but also to optimally engage parents and provide a basis for parental choice within the framework of the current ECE MDS. Attention is given to the quality and availability of programs and supports for children B-5, with particular attention dedicated to programs and supports for children with special needs and children who are dual language learners (DLLs).

Further, the Needs Assessment identifies indicators of progress in the Territory's current ECE MDS and acknowledges the ongoing work needed to fully implement the Territory's QRIS, VIS2Q. The information on interagency collaboration and the evidence regarding system integration provide opportunities to strengthen the Territory's ECE MDS. This is particularly true with respect to the need to embrace the noted gap areas as opportunities to improve the Territory's ECE MDS by strategically addressing each of the gap areas and working towards improving and expanding communications across the entire ECE MDS. This is a significant opportunity to bring parents, private childcare center owners/operators and other providers to the table and ensure that policies are clearly

articulated and disseminated in support of a high-quality ECE MDS that all stakeholders support and understand the value of their voice and the need for their unique contributions.

It is crucial that the approach the Territory embraces to operationalize clear, consistent, and inclusive engagement of stakeholders is anchored in an intentional and deliberative structure that is steeped in open and redundant communication as well as feedback loops that require regular, active participation with operationally defined and agreed-upon outputs. One of the most powerful "findings" coming out of the completion of this Needs Assessment is the consistency with which a broad range of stakeholders either deferred to complete one of the three surveys targeted to various stakeholder groups, or, when responding, left a number of items blank. There could be a number of reasons for this, to include the framing of some of the questions on the survey (some questions framed from a state-local point of view, which does not comport with how the Territory functions), to not feeling comfortable with having the knowledge-base to respond to the questions, as several stakeholders shared, or other factors that may be more nuanced.

Regardless of the reasons that influenced stakeholders' responses to and participation in data collection activities, the Birth to Five stakeholders are receiving and sending strong signals regarding the need for more extensive and more effective communication relative to the Territory's ECE MDS, which will be crucial to get the Virgin Islands community to the place of having a high-quality ECE MDS that is able to meet the needs of all our children and provide them with the tools to reach their potential and thrive. One strategy to move the needle in this area is to publicly declare the critical nature and value of preschool development at the Territorial level and identify and support some champions and change agents in key leadership positions within the Territory's ECE MDS.

Responsible and responsive facilitation of the process in a manner that receives the support of the highest levels of the VI Government and maintains communications with the B-5 families, key stakeholders within the ECE MDS, and the general public would be major steps towards a coordinated system that meets the needs of the USVI Community. The development of a graphic representation of the Territory's desired ECE MDS, with a clear delineation of how children, parents, families, providers, advocates, policymakers, the

community, and funders could serve as a blueprint for how to engage and sustain the engagement of stakeholders.

This blueprint, coupled with the Territory's ECE MDS Strategic Plan and Program Performance Evaluation Plan are essential initiatives/mechanisms for our success as we continue on our *Road to Success* with respect to Early Childhood Care and Education in the U.S. Virgin Islands. It is only within this context, with clear, consistent and inclusive engagement that the Territory will realize its efforts with respect to the development of a high-quality ECE MDS within which children birth through five years of age, and their families, receive the care and support needed on the *Road to Success*, which will be measured by thriving children, ready to be successful in the K-12 educational system in the USVI, no matter their economic backgrounds.

CHAPTER V: IMPLICATIONS FOR STRATEGIC PLANNING

The approach and governance structure of the development process of the Needs Assessment presented significant opportunities to identify gaps in data, research, and implementation of the USVI ECE mixed-delivery system. The information presented here is critical to the development of a USVI ECE strategic plan that will focus on the Territory's human, physical and financial resources, policies, and time on the most impactful approach for the development of an ECE mixed-delivery system designed with the capacity to meet the needs of children from birth to age five, their families, and the community. The gaps are presented by section (Sections III.4 through III.11) and the location of the associated issues are indicated by page numbers in parentheses at the end of each gap statement.

KEY GAPS AND BARRIERS IN ECE PROGRAMS AND SERVICES IN THE USVI

ECE PROGRAMS AND SERVICES: WHO IS BEING SERVED

- Inadequate data collection and publishing of B-5-specific data on health and education programs and services. (pp. 30,31)
- Absence of a fully functional integrated and comprehensive system for health and education services to determine the proportion of children B-5 being served. (pp. 30, 31 37)
- Insufficient cooperation and data-sharing agreements exist across B-5 programs and services in the Territory. (p. 37)

SYSTEMS AND PARTNER COLLABORATIONS AND SUPPORTS

- The community partnerships enumerated for EHS and HS are either Memoranda of Understanding (MOUs), or partnership or informal agreements between agencies, but there is no unified coordination that is officially organized or supported across the private and public sector actors involved in early childcare and education in the Territory. (pp. 40, 44)
- Existing data collection and reporting approaches do not maximize the utilization of data to support coordination or transparent communications to parents or other key stakeholders in the Territory's ECE MDS. (pp. 44, 47)

QUALITY AND AVAILABILITY OF PROGRAMS AND SUPPORTS

- Implementation of the graduated Quality Standards (QRIS) has not been completed and no timeframe is available. (pp. 47, 74)
- Insufficient coordination of data and information addressing limited programs and/or supports for parents who are employed, looking for work, or in training who need to access child care – to include transportation challenges. (p. 47)
- Insufficient data that describes and documents currently funded programs' capacity to assist clients at the levels needed. (pp. 44, 49)

- Insufficient behavioral health care support for children B-5. (pp. 50, 51)
- Insufficient data to address the reduction in challenges with timeliness and availability of services for children, B-5, with disabilities. (pp. 47, 48, 72)
- Limited availability of interpreters to support parents for whom English is not their native tongue and ensure accessibility to needed programs and services for children B-5. (p. 50)
- Paucity of data regarding coordination and availability of support services in the areas of behavioral health, housing, transportation, employment underpin increased stress and hardship for the birth to five population and their families, especially single-head households. (p. 47)
- Lack of consolidated data and information relative to support services associated with behavioral health for the birth to five population. (pp. 50,51)
- Paucity of data on the maintenance of professional knowledge and competence in ECE teachers and caregivers in the USVI MDS. (p. 53)

INDICATORS OF PROGRESS

- Paucity of data and information regarding approaches used in the USVI to track progress with respect to the quality of ECE programs in the Territory, including the amount of sharing with partners and collaborators. (pp. 59. 60, 86)
- Lack of a common curriculum and coordinated approach to assessment across private childcare programs. (pp. 59, 86)
- Insufficient analyses of existing data and information on patterns of student performance and outcomes, including factors associated with student performance based on type of ECE setting as well as progress through the Kindergarten year. (p. 77)

TRANSITION SUPPORTS

- Lack of a formalized system for the development and promulgation of policies around the transition process across the full range of transitions and transition supports. (p. 87)
- Lack of formalized system to ensure the 2015 AIA, VIDE SOSE Procedural Manual (2011) and the Revised Special Education Rules (2009) are updated and related informational materials developed and shared with all persons who participate in the transition process, beyond the administrative/managerial personnel specifically designated as part of the transition process. (p. 87)
- Lack of formalized parent feedback on transition processes that would be open to all families who have had children transition from the ECE to K-12 system, to include transition from Part C to Part B services, transition from an ECE setting to Kindergarten, or transition from Kindergarten to the first grade. (p. 93)

ECE FACILITIES

- Inadequate or non-existent disaster preparedness plans that provide protocols and identification of resources to address emergencies and natural hazard for public and private day care centers. (p. 96)

- Reduced numbers of ECE facilities available to serve B-5 children on HS waiting list due to damage sustained as a result of Hurricanes Irma and Maria. (pp. 95, 96)
- Unavailability of data that speak to the accessibility of currently licensed ECE facilities for physically challenged children and/or parents. (pp. 99, 100)

ECE FUNDING AND RESOURCE USE

- Lack of disaggregated data from funding streams does not provide a clear picture of annual monetary support inputs that address the education, health, or childcare programs and services for birth to age five children in the USVI ECE MDS. (p. 101)
- Lack of articulated strategy or policy regarding integration of ECE funding sources to optimize the reach of existing ECE funds that flow into the Territory. (pp. 101, 102)

POTENTIAL THREATS

Potential threats to an effective USVI ECE Mixed-Delivery System arise from the impacts on the natural environment, socio-economic conditions in the Territory, and institutional policies and practices of stakeholders in the MDS. An action or condition becomes a threat when it creates or is an obstacle to parents, providers – including childcare center owners, and public administrators providing a learning environment that supports healthy early childhood development and readiness for learning in birth to age five children. The USVI ECE Needs Assessment identifies gaps in research regarding many aspects of the USVI ECE MDS, which become even more important when plans and responses are being developed to positively respond to the potential threats listed in the table below.

Table 22
Areas of Impact of Threat

Potential Threat	Examples of Threat	Natural Environment	Socio-economic Aspects	Institutional Policies and Practices
Pandemics/Epidemics	COVID 19/Dengue outbreak	X	X	X
Disruptive natural hazard events	Hurricanes -Category 5 or severe earthquakes	X	X	X
Climate Change driven impacts	Heat waves and sea-level rise	X	X	X
Administration changes	Changes in national and or local governments	X	X	X
Lack of staff capacity and staff loss	Insufficient data management staff or training for staff; budget reductions		X	X
Economic recession	Residual effects of 2008 and forecasted 2020 recessions		X	X

KEY OPPORTUNITIES

The USVI ECE Needs Assessment used a participatory approach to identify and review data and information regarding governance infrastructure, stakeholder relationships, outputs of programs and services, and capacity of providers involved in the current USVI ECE MDS. The advances that have been made and the challenges that exist illuminate a number of opportunities for an improved and more effective ECE MDS in the Territory. The list below presents the opportunities arising from the Needs Assessment as the information background and rationale for the goals of the USVI ECE Strategic Plan.

The USVI ECE Needs Assessment presents opportunities to:

- Review, expand and optimize formal and informal agreements among private and public sector stakeholders involved in early childhood care and education.
- Increase and improve the coordination among stakeholders in the ECE MDS, especially with respect to data collection and sharing and governance arrangements.
- Expand and improve the engagement and communications to parents of birth to age five children.
- Increase and improve the quality of early childhood care programs with a focus on continued professional development opportunities for providers.
- Review and increase types of support for children birth to age five and their families, especially regarding transitioning, health care, transportation, access to good nutrition and employment opportunities.

The information and data presented in the Needs Assessment provide a very detailed picture of the conditions and issues associated with the USVI ECE MDS, and offer strong indicators for the development of the Territory's ECE MDS strategic plan. Further, in acknowledging the potential threats to the delivery of effective early child care and education, the Needs Assessment provides both a foundation and framework that can inform the strategic planning process such to facilitate optimal collaboration among key stakeholders to embrace opportunities to significantly increase the number of children birth to age five who will thrive and become life-long learners.

CHAPTER VI: NEXT STEPS

One of the critical actions that will be undertaken is the dissemination of the Needs Assessment. This dissemination will take multiple forms. First, the State Entity will host a number of sessions to present the Needs Assessment to key stakeholder groups – funders, policy makers, childcare facility owners and operators, caregivers, parents, advocates, and the research community. Additionally, the Needs Assessment will be uploaded to the PDG B-5 microsite at the University of the Virgin Islands and hotlinks will be established with partner agencies and organizations serving parents and families of children B-5. This will facilitate easy access to the Needs Assessment from any partner agency website by all stakeholders. Further, key elements of the findings will be transformed into Fact Sheets, brochures, and other documents targeted to various stakeholder groups that will be accessible via social media and print.

Another major step will be the utilization of information presented in this Needs Assessment for the development of the Territory's new ECE MDS Strategic Plan as the U.S. Virgin Islands continues its journey on *The Road to Success: Developing an Early Childcare and Education Mixed Delivery System for the B-5 Population in the USVI*. Using the findings of the Needs Assessment, with a particular focus on the gaps identified, the Territory's ECE MDS Strategic Plan will provide the roadmap for moving the Territory towards having thriving children that reach their academic potential. This roadmap will be developed being mindful of potential threats, yet embracing the opportunities that are before the Territory to draw on the collective strength of the various stakeholder groups. This collective strength will serve as a catalyst to set the course for transforming the current Territory's ECE MDS into an accessible, high quality system marked by collaboration, innovation, and competent, compassionate, leaders and providers working with engaged, informed parents to ensure that all children, B-5 in the Territory have access to high quality ECE programs and services.

The State Entity, working with the SAC and PAOS, will develop elements of the strategic plan and convene stakeholder groups to provide feedback on different elements. A key stakeholder group will be the parents of children B-5 that will be active participants of the strategic plan development. Additionally, key policymakers will be included in the strategic

plan development process to ensure that the fiscal support needed to support the implementation of the strategic plan is available.

Further, the Needs Assessment will be used to inform the expansion and completion of outputs in support of expanding parent knowledge, choice, and engagement. Particular attention will be given to information shared by parents through the parent survey, as well as elements of the Inclusion Self-Assessment Survey, the general Stakeholder Survey, and the Transition Survey, that speak to engaging parents by integrating strategic actions and outreach activities to ensure that parents are included as collaborators in all facets of the Territory's ECE MDS, from policy development, to program delivery, to program evaluation.

The results of the Needs Assessment will also be instrumental as work on the Best Practices goal continues. The goal is to ensure that gap areas identified that can be informed through best practices presented in the ECE literature and documented as positively impacting program quality and outcomes for the B-5 population and their families, and can be included in the outputs to be developed and shared with the Territory's ECE MDS funders, leaders, policy makers and providers.

Additionally, the required Program Performance Evaluation Plan (PPEP) to assess progress on the implementation of the Territory's ECE MDS Strategic Plan will be completed. The development of the PPEP will also be informed by the Needs Assessment and will be aligned with the Strategic Plan.

As next steps are addressed, policymakers will be engaged to obtain commitments to support, through policy and funding, the full implementation of the Territory's ECE MDS Strategic Plan, which will integrate elements of the outputs in support of parental knowledge, choice, and engagement, as well as identified ECE best practices. The Territory will continue moving forward on the *Road to Success* and will assess its success in doing so by implementing the PPEP and regularly updating stakeholders on progress being made in optimizing outcomes for the B-5 population in the U.S. Virgin Islands. Further, the Needs Assessment will serve as catalyst for collective change that leads the Territory's development of sustainable, high quality ECE outcomes for the most vulnerable in our B-5 population.

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APPENDICES

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Appendix IB: Workgroups, Charges, and Objectives

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Appendix IIIB: Synopses of Quantitative Instruments

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DISTRICTS AND SUB-DISTRICTS OF THE U.S. VIRGIN ISLANDS

St. Thomas

1. Charlotte Amalie
2. East End
3. Northside
4. Southside
5. Tutu
6. Water Islands
7. West End

St. John

1. Central
2. Coral Bay
3. Cruz Bay
4. East End

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1. Anna's Hope Village
2. Christiansted
3. East End
4. Frederiksted
5. Northcentral
6. Northwest
7. Sion Farm
8. Southcentral
9. Southwest

St. Croix