

| Priority Needs                                  | Five-Year Objectives   | Strategies                       | Evidence-Based or -Informed Strategy Measures   | National and State Performance Measures | National and State Outcome Measures   |
|---|--|----------------------------------|---|---|---|
| <b>Women/Maternal Health</b>                    |  |                                  |   |   |   |
| Improve care coordination for postpartum women. | To increase the percentage of women who attended a postpartum checkup within 12 weeks after giving birth from 26% to 31% by 2030 | Patient Navigation               | ESM PPV.1 - Percent of postpartum mom receiving a reminder call.  | NPM - Postpartum Visit                  | <u><a href="#">Linked NOMs:</a></u><br>Maternal Mortality<br>Neonatal Abstinence Syndrome<br>Women's Health Status<br>Postpartum Depression<br>Postpartum Anxiety |
| <b>Perinatal/Infant Health</b>                  |  |                                  |   |   |   |
| Improve infant feeding and nutrition.           | Increase the percentage of infants exclusively breastfed through 6 months by 5% from 16% to 21% by 2030.                         | Breastfeeding Promotion Programs | ESM BF.1 - Percent of postpartum women who ever breastfed at discharge after birth.<br>ESM BF.2 - Percentage of providers and health educators who were more confident in providing breastfeeding education to pregnant women after receiving breastfeeding TA training.<br>ESM BF.3 - Percentage of postpartum women who received a home-visit from any DOH personnel that works closely with this | NPM - Breastfeeding                     | <u><a href="#">Linked NOMs:</a></u><br>Infant Mortality<br>Postneonatal Mortality<br>SUID Mortality   |

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|                |                      |            | <p>population, providing breastfeeding reminders and support</p> <p>ESM BF.4 - Number of breastfeeding promotional translated materials disseminated throughout the community.</p> <p>ESM BF.5 - Percent of workplaces who received a talk on breastfeeding support and FLSA.</p> |   |                                     |

| Child Health  |   |                   |   |                               |  |
|---|---|-------------------|---|-------------------------------|--|
| Developmentally appropriate care and services are available for all children. | Increase the Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year by 5%, from 16.5% to 21.5% by 2030. | Provider Training | <p>ESM DS.1 - Percent of providers serving children and families participating in learning collaborative.</p> <p>ESM DS.2 - Number of providers that initiated developmental screenings with parents during medical/home visits after receiving developmental screening training.</p> <p>ESM DS.3 - Number of ASQ questionnaires disseminated to all Well Child Clinics</p> | NPM - Developmental Screening | <p><u><a href="#">Linked NOMs:</a></u></p> <p>School Readiness</p> <p>Children's Health Status</p> |

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|   |   |                   | <p>(WCC).</p> <p><b>Inactive - ESM DS.4</b><br/> <i>- Percentage of children ages 9 through 35 months completing an ASQ questionnaire in the past 12 months.</i></p> <p><b>Inactive - ESM DS.5</b><br/> <i>- Translate the ASQ tools into the Samoan language.</i></p>  |   |  |
| Developmentally appropriate care and services are available for all children. | Increase the percent of children with a medical home in 2030 by 5%. | Care Coordination | <p>ESM MH.1 - Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population</p> <p>ESM MH.2 - The percentage of children ages 4 - 17 years of age who attends at least 90% of their appointed Bicillin shots.</p> <p><b>Inactive - ESM MH.3</b><br/> <i>- Official MOU for preventive medical screenings in school to include vision is endorsed by governing directors.</i></p> <p>ESM MH.4 - Percent of children ages 3 through 14 years received a vision</p> | NPM - Medical Home                      | <p><b>Linked NOMs:</b></p> <p>Children's Health Status</p> <p>CSHCN Systems of Care</p> <p>Flourishing - Young Child</p> <p>Flourishing - Child Adolescent - CSHCN</p> <p>Flourishing - Child Adolescent - All</p> |

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|                |                      |            | <p>screening.</p> <p>ESM MH.5 - Percentage of active CYSHCN clients who completed an annual medical check-up in the past 12 months.</p> <p>ESM MH.6 - Percent of CYSHCN ages 33-36 months, and ages 14 to 17 engaging in at least 1 transition meeting.</p> <p>ESM MH.7 - Percent of children ages 0 through 17 tested for Strep throat infections and treated.</p> <p>ESM MH.8 - Percentage of children ages 3 through 17 screened for RHD using echocardiography in the past year.</p> |   |                                     |

## Adolescent Health

|  |  |                   |   |                             |   |
|--|--|-------------------|---|-----------------------------|---|
| Promote adolescent health through effective care coordination. | Increase the percentage of children with and without special health care needs, ages 0 through 17, who receive needed care coordination from 50% to 55% by 2023. | Patient Navigator | <p>ESM AWV.1 - Percent of adolescents who received a depression screening during a wellness visit annually.</p> <p>ESM AWV.2 - Percent of adolescents ages 12 through 17 receiving cardiology screening for Rheumatic Heart</p> | NPM - Adolescent Well-Visit | <p><u><a href="#">Linked NOMs:</a></u></p> <p>Teen Births</p> <p>Adolescent Mortality</p> <p>Adolescent Motor Vehicle Death</p> <p>Adolescent Suicide</p> <p>Adolescent Firearm Death</p> <p>Adolescent Injury Hospitalization</p> <p>Children's Health Status</p> <p>Child Obesity</p> <p>Adolescent Depression/Anxiety</p> <p>CSHCN Systems of Care</p> |
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|                |                      |            | Disease in schools.<br>ESM AWV.3 - Percent of children ages 12 through 17 receiving reproductive health talk in schools.<br>ESM AWV.4 - Percentage of children ages 4 to 17 screened positive for RHD in schools. |   | Flourishing - Child Adolescent - CSHCN<br>Flourishing - Child Adolescent - All |

## Children with Special Health Care Needs

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|---|---|-------------------|--|--------------------|---|
| Enhance System of Care for Children and Youth with Special Health Care Needs. | Increase the percent of children 0 -17 with special health care needs having a medical home from 7.9% to 13% by 2030. | Patient Navigator | ESM MH.1 - Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population<br>ESM MH.2 - The percentage of children ages 4 - 17 years of age who attends at least 90% of their appointed Bicillin shots.<br><i>Inactive - ESM MH.3 - Official MOU for preventive medical screenings in school to include vision is endorsed by governing directors.</i><br>ESM MH.4 - Percent of children ages 3 through 14 years | NPM - Medical Home | <b>Linked NOMs:</b><br>Children's Health Status<br>CSHCN Systems of Care<br>Flourishing - Young Child<br>Flourishing - Child Adolescent - CSHCN<br>Flourishing - Child Adolescent - All |
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|---|---|--|--|---|-------------------------------------|
|   |   |  | <p>received a vision screening.</p> <p>ESM MH.5 - Percentage of active CYSHCN clients who completed an annual medical check-up in the past 12 months.</p> <p>ESM MH.6 - Percent of CYSHCN ages 33-36 months, and ages 14 to 17 engaging in at least 1 transition meeting.</p> <p>ESM MH.7 - Percent of children ages 0 through 17 tested for Strep throat infections and treated.</p> <p>ESM MH.8 - Percentage of children ages 3 through 17 screened for RHD using echocardiography in the past year.</p> |   |                                     |
| Mitigating and addressing rheumatic heart disease as a critical healthcare focus. | Increase the percent of RHD clients compliant with at least 80% of their scheduled prophylaxis from 90% to 95% by 2030. | Text Message-Based Appointment Reminders | No ESMs were created by the State. ESMs are optional for this measure.   | SPM 2: Percent RHD patients ages 4 through 21 who are at least 80% compliant with their secondary prophylaxis in the past year. |                                     |
| Mitigating and addressing rheumatic heart disease as a critical                   | Increase the percent of new RHD cases receiving care coordination by 5% in 2030.  | Patient Navigation.                      | No ESMs were created by the State. ESMs are optional for this measure.   | SPM 1: Rate per 1,000 of children, ages 3 through 17, diagnosed with Rheumatic Heart Disease.                                   |                                     |

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| healthcare focus.  |   |   |  |  |                                     |
| <b>Cross-Cutting/Systems Building</b>                                |   |   |  |  |                                     |
| Refine the MCH database in SILAS to capture all MCH reporting needs. | At least 80% of NOMs are captured in SILAS by 2030. | MCH Database Infrastructure Improvement | No ESMs were created by the State. ESMs are optional for this measure. | SPM 3: Percent of MCH data reports readily available in SILAS. |                                     |