American Samoa State Action Plan Table 2027 Application/2025 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Improve care coordination for postpartum women.	By 2030, increase the percentage of women who attended a postpartum checkup within 12 weeks after giving birth from 26% to 31%.	Patient Navigation	ESM PPV.1 - Percent of postpartum women contacted by a patient navigator within two weeks of delivery.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Improve infant feeding and nutrition.	A) By 2030, increase the percentage of infants ever breastfed from 73% to 80%. B) By 2030, increase the percentage of infants exclusively breastfed through the first 6 months, from 9% to 14%.	A) Mothers of infants participating in breastfeeding education during pregnancy. B) Expand lactation counseling and breastfeeding support services for postpartum mothers.	***Inactive -*** *ESM BF.1 - Percent of infants who were ever breastfed.* ***Inactive -*** *ESM BF.2 - Percent of eligible mothers participating in breastfeeding support programs.* ***Inactive -*** *ESM BF.3 - Percentage of postpartum women who received a home-visit from any DOH personnel that works closely with this population, providing breastfeeding reminders and support* ***Inactive -*** *ESM BF.4 - Number of breastfeeding promotional materials*	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality

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			disseminated throughout the community were translated into Samoan. ESM BF.5 - Percent of ASG workplaces who received a talk on breastfeeding support and FLSA.		
Child Health					
Developmentally appropriate care and services are available for all children.	By 2030, increase the percentage of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year from 16.5% to 21.5%.	Early Screening/Referral	***Inactive -*** *ESM DS.1 - Percent of providers serving children and families participating in Developmental Screening Training.* ***Inactive -*** *ESM DS.2 - Percent of providers that initiated developmental screenings with parents during medical/home visits after receiving developmental screening training.* ESM DS.3 - Number of ASQ questionnaires printed and disseminated to all Well Child Clinics (WCC). ***Inactive -*** *ESM DS.4 - Percentage of children ages 9*	NPM - Developmental Screening	**Linked NOMs:** School Readiness Children's Health Status

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			through 35 months completing an ASQ questionnaire in the past 12 months. ***Inactive -*** *ESM DS.5 - Translate the ASQ tools into the Samoan language.*		
Developmentally appropriate care and services are available for all children.	By 2030, increase the percent of children without special healthcare needs, ages 0 through 17 years, who have a medical home, from 43% to 48%. (Data Source: Jurisdictional Survey)	Medical Home Care Coordination	ESM MH.1 - Percentage of active CYSHCN clients who completed an annual medical check-up in the past 12 months. ESM MH.2 - Percent of patient navigators who meet or exceed competency standards for care coordination. ESM MH.3 - Percent of CYSHCN ages 14 to 17 engaging in at least 1 transition meeting. ***Inactive -*** *ESM MH.4 - Not applicable. This is an SPM Measure (repetitive)* ***Inactive -*** *ESM MH.5 - Not applicable. This is an SPM Measure (repetitive)* ***Inactive -*** *ESM MH.6 - Not applicable. This is an SPM Measure (repetitive).* ***Inactive -*** *ESM MH.7 - Not applicable. This*	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			is an SPM Measure (repetitive) ***Inactive -*** *ESM MH.8 - Official MOU for preventive medical screenings in school to include vision is endorsed by governing directors.*		
Developmentally appropriate care and services are available for all children.	By 2030, increase the percentage of children ages 5 through 10 who received a vision screening, using a PlusOptix machine, in the past year from 6.7% to 27%.	School-based vision screening	SPM ESM 1.1 - Percentage of elementary schools who participated in the vision screening program in the past year.	SPM 1: Percent of children ages 5 through 10 who received a vision screening in the past year.	
Adolescent Health					
Promote adolescent health through effective care coordination.	By 2030, increase the percentage of adolescents ages 12 through 17, who had a preventive medical visit in the past year rom 25% to 33%.	Medical Home	***Inactive -*** *ESM AWV.1 - Percent of adolescents who had a preventive medical visit in the past year* ESM AWV.2 - Percent of adolescents ages 12 through 17 participated in wellness check-up promotional talks in school or community events. ESM AWV.3 - Percent of children ages 12 through 17 receiving reproductive health talk in schools. ESM AWV.4 - Percentage of	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			children ages 12 through 17 who are detected obese or overweight and referred to CHC for a medical check-up.		
Mitigating and addressing Rheumatic Heart Disease as a critical healthcare focus.	By 2030, increase the percentage of children ages 5 through 17 who received an echocardiogram screening in the past year from 17.5% to 23.5%.	School-based cardiac-echo screening and care coordination.	SPM ESM 2.1 - Percentage of schools who participated in the RHD Screening Program in the past year.	SPM 2: Percentage of school age children ages 5 through 17 years who received a heart echocardiogram screening for RHD in the past year.	
Children with Special Health Care Needs					
Enhance System of Care for Children and Youth with Special Health Care Needs.	By 2030, increase the percent of children with and without special health care needs ages 0 through 17, who are reported by a parent to have received all needed help with care coordination from 43% to 47% by 2030.	Medical Home - Care Coordination	ESM MH.1 - Percentage of active CYSHCN clients who completed an annual medical check-up in the past 12 months. ESM MH.2 - Percent of patient navigators who meet or exceed competency standards for care coordination. ESM MH.3 - Percent of CYSHCN ages 14 to 17 engaging in at least 1 transition meeting. ***Inactive -*** *ESM MH.4 - Not applicable. This is an SPM Measure (repetitive)* ***Inactive -*** *ESM MH.5 - Not applicable. This is an SPM Measure*	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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Mitigating and addressing Rheumatic Heart Disease as a critical healthcare focus.	By 2030, increase the percent of RHD clients compliant with at least 90% of their scheduled prophylaxis from 60.1% to 70%.	Patient Navigator	SPM ESM 3.1 - Percent of newly diagnosed RHD cases enrolled in care coordination within 30 days of diagnosis.	SPM 3: Percent of RHD clients ages 5 through 21 yrs compliant with at least 90% of their scheduled prophylaxis.	
Cross-Cutting/Systems Building					
Enhance the MCH information system, to support comprehensive Title V reporting and program management.	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 4: Percent of required Title V reports that can be generated directly from SILAS.	