American Samoa State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or – Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.	1. Collaborate with all Prenatal Care Providers and support programs (BCCP, MIECHV, CHC, HIV/STD, NCD, Primary Care, Prenatal Clinics, WIC, Intersections Inc., Media) to promote and refer women for early prenatal care services. 2. Provide mass media campaigns to promote pregnant women seeking early prenatal care in the community. 3. Ensure all Health Education materials are translated appropriately and standardized across all clinics and programs. 4. Promote Maternal and Postpartum Depression Screening and referral for counseling and/or treatment. 5. Ensure assigned staff and CHC nurses to conduct postpartum reminder calls. 6. Ensure all pregnant women coming in for their first visit get referred for a dental screening. 7. Provide mass media campaigns to promote preventive medical visits for all women in child bearing ages. 8. Recruit women ages 18-44 to utilize the Breast & Cervical Cancer Program (BCCP) after hour clinic for pap smear screening (MCH will collaborate with BCCP on supplies and compensation for staff). 9. Formulate and disseminate a women's check-up passport to improve tracking and monitoring of age-appropriate visits and screening appointments.	Increase percentage of pregnant women beginning prenatal care at first trimester by 2% every year, from 35.9% in 2019 to 45% in 2024. By 2024, increase the percentage of women with a preventive medical visit in the past year by 2% every year for the next five year.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: Percent of women who report scheduling a preventive visit based on information obtained through various media outlets.* ESM 1.2: Percent of Providers receiving Technical Assistance Training in Prenatal Care Standards of Care and Provider Competencies. ESM 1.3: Percent of postpartum women who received a depression screening and were referred to a behavior health counselor/psychologist. ***Inactive -*** *ESM 1.4: Percent of pregnant women who receive at least one preventive dental service in the past year.*	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live

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	10. Provide & Support online training for providers on quality care for non-pregnant women.			***Inactive -*** *ESM 1.5: Percentage of women who received the COVID-19 vaccine during a wellness visit.*	births NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Perinatal/Infant Health					
Families are empowered to make educated choices about infant health and well-being.	Review and revise Baby Friendly Policies at LBJ Hospital, to ensure babies are exclusively breastfed in the first 24 hours unless medically contraindicated. Acquire Breastfeeding Training from WIC and AMCHP for providers and implement them twice a year. Establish a Breastfeeding Hotline for ASDOH and ensure it is well promoted and utilized. Partner with WIC and MIECHV and ensure home visitor are well trained to promote breastfeeding in the homes. Ensure the American Samoa Breastfeeding Coalition Members meet at least 6 times a year to plan and promote annual actives to accomplish ESMs.	Increase percentage of breastfeeding mothers by 5% in 2024. Increase by 5%, 6 months infants who exclusively breastfeed in 2024.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	ESM 4.1: Percentage of breastfeeding mothers who reported they were more confident breastfeeding in the first six months of birth after receiving breastfeeding education. ESM 4.2: Percentage of providers and health educators who were more confident in providing breastfeeding education to pregnant women after receiving breastfeeding TA training.	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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				Inactive - *ESM 4.3: Percentage of BF women who access the virtual chat room for lactation and peer counseling.* ESM 4.4: 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 4.5: Percentage of Breastfeeding Feeding Coalition Members who report they meet at least 6 times a year* ***Inactive -*** *ESM 4.6: Percent of House and Senate who are aware of the importance of paid Maternity Leave.*	
Establish a Newborn Metabolic Screening Program in American Samoa	Convene an NBS Advisory Committee. Develop a Birth Condition Surveillance reporting system Partner with NBS Excel Awardee Ensure all newborns receive BSS by year 2025.	By July 1, 2024, AS DOH will initiate NBS for congenital hypothyroidism (CH). By July 1, 2024, AS DOH will initiate CCHD screening by pulse oximetry.	SPM 1: Percent of newborns receiving Blood Spot Screening		

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	Establish MCH & Screening System to Support Individuals & Families Throughout the Lifespan	AS DOH and New Zealand NBS will identify appropriate Advisory Committee membership, to include families and community members, form a project Leadership Team, and define roles and responsibilities by August 30, 2023. The full Advisory Committee will begin meeting quarterly by September 30, 2023. The Advisory Committee Leadership Team will begin meeting monthly by September 30, 2023.			
Child Health					
Developmentally appropriate care and services are available for all children.	Promote developmental screening rates. Promote BMI documentations and weight management of children ages 0-5 years.	By January 2024, two meetings will be initiated to establish an interagency committee on Developmental Screenings. By March 30, 2024, 75% of CHC Providers will complete a refresher CME session on Developmental Screenings for Children ages 0-3 years. By September 30, 2024, MCH Program Staff will complete 4 outreach activities targeting families and communities regarding developmental screening. By March 30, 2024, 50% of CHC	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	ESM 6.1: Percent of providers serving children and families participating in learning collaborative. ESM 6.2: Number of providers that initiated developmental screenings with parents during medical/home visits after receiving developmental screening training.	NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

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		providers will report they've received CME presentations on BMI screening, behavioral counseling and referral and are confident to provide such services.			
Developmentally appropriate care and services are available for all children.	Partner with the Immunization Program to produce two Public Service Announcements and advertise on local media outlets and social media.	By July 2024, increase immunization coverage of children ages 35 months who receive up to date routine vaccinations by 2%.	SPM 2: Percent of children ages 3 who have completed their age-appropriate routine vaccinations.		
Developmentally appropriate care and services are available for all children.	Revise current standard operating procedures and provide refresher training for all medical staff at dental clinics and well baby clinics, at least twice a year. Provide promotional oral hygiene kits to give out in the month of February, Children's Dental Health Month. Record a Samoan PSA video promoting what to expect when getting a fluoride varnish treatment at the Well Baby Clinic.	By June 30, 2024, increase the percentage of children 0-3 years receiving at least two topical fluoride varnish treatment and oral hygiene instructions.	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: Percent of children 0-3 years receiving fluoride varnish at least twice a year.	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Adolescent Health					
Communities and providers support adolescents' physical, mental and emotional health.	Initiate a Taskforce who will introduce to legislatures a Healthy Schools Policy to mandate all school children in Elementary and High Schools to to receive a wellness check-up within 3 months prior to the start of every school year. Generate an Adolescent Health Check-up Passport according to the Well-visit roadmap. - Weight management (7th grade) - Reproductive health (8th grade) - Mental health (9th grade) Collaborate with related partners such as Intersections Inc., ASNOC, Faithbased Youth Organizations, Teen Challenge, DOE and Private	Increase the percentage of adolescents with a well visit by 2% every year, from 48.2% in 2019 to 58.2% in 2024.	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	***Inactive -*** *ESM 10.1: Percent of adolescents who have a wellness check-up passport.* ESM 10.2: Percent of adolescents who received a depression screening during a wellness visit annually.	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000

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	schools to refer clients and students for annual medical check-ups.			***Inactive -*** *ESM 10.3: Percent of adolescents that scheduled a wellness checkup after hearing/reading the importance of an annual checkup through mass media campaigns.*	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of

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					adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
Children with Special Health Care Needs					
Improve System of Care for Children and Youth with Special Health Care Needs.	Select a suitable curriculum based on the needs of children with special needs who requires healthcare provider intervention on how to identify developmental delays and offer proper diagnosis. Revise and update standard operating procedure (SOP) on care coordination for families of children and youth with special healthcare needs (CYSHCN). Collaborate community outreach programs with Leo O Aiga (F2FHIC) to promote families of CYSHCN enrollment by 10% each year (2021-2025). Strategically provide transition awareness and training for providers and families.	50% of CHC providers received MCHAT training and report they are confident to provide screening for children with Autism Spectrum Disorder at 16 months and 30 months.	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	ESM 11.1: Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population ESM 11.2: Percent of providers that reported they were more confident using the MCHAT screener after receiving autism screening training ***Inactive -*** *ESM 11.3: Percent of CSHCN families receive transition training.* ESM 11.4: The percentage of children ages 4 - 17 years of age who attends at least 90% of their appointed Bicillin shots.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
Reduce Rates	Continue to provide call reminders 1 week, then 1 day prior to to	Increase by 2% the percentage of	SPM 3: Rate per 10,000		

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of Rheumatic Heart Disease	appointment date. Continue to provide mass media campaign in promoting RHD Clinic. Ensure to enter encounters and Bicillin shots in SILAS to build the RHD Registry for tracking and monitoring.	children ages 4 - 17 years of age who attends 90% of their appointed Bicillin shots annually, by September 30, 2024.	children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.		
Cross-Cutting/Systems Building					
Establish a functional RHD registry in the MCH centralized Database SILAS.	Build an accessible RHD registry in SILAS and ensures it has the capability for appointment reminders, antibiotic documentations, Cardio echo results, cardiology notes and other medical reports.	Improve the Rheumatic Fever and Rheumatic Heart Disease (RHD) registry in SILAS to improve the monitoring, surveillance, and management of these conditions.	SPM 4: Build a functional RHD Registry in SILAS to capture all presumptive and confirmed cases of Rheumatic Fever and Rheumatic Heart Disease.		