Maternal and Child Health Services Title V Block Grant

American Samoa

FY 2022 Application/ FY 2020 Annual Report

Created on 10/22/2021 at 4:57 PM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

DEPARTMENT OF PUBLIC HEALTH
PO Box 5666
American Samoa Government
Pago Pago, American Samoa 96799

LEMANU P.S. PELETI
Governor

TALAUEGA E.V.ALE
Lieutenant Governor

Public Health
Prevent. Promote. Protect.
American Samoa
Department of Health
MOTUSA T. NUA
Director

FARAITOAFA M. UTU
Deputy Director

August 30, 2021

Christopher Dykton, MA
Acting Director
Division of State and Community Health (DSCH)
Maternal Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services (DHHS)
5600 Fishers Lane, Rockville, MD 20857

Dear Mr. Dykton,

With this letter of transmittal, I am pleased to submit American Samoa's application for the Title V Maternal and Child Health (MCH) Services Block Grant. The 2020 Annual Report and the 2022 Title V Block Grant application have been submitted online through the HRSA Electronic Handbooks (EHBs) Title V Information System as required.

If you have any questions concerning this application, please contact Dr. Anaise Uso via email at anaise@doh.as or call (684) 633-4008.

Sincerely,

Vesi Talalelei Fautanu,
Acting Director, Department of Health

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

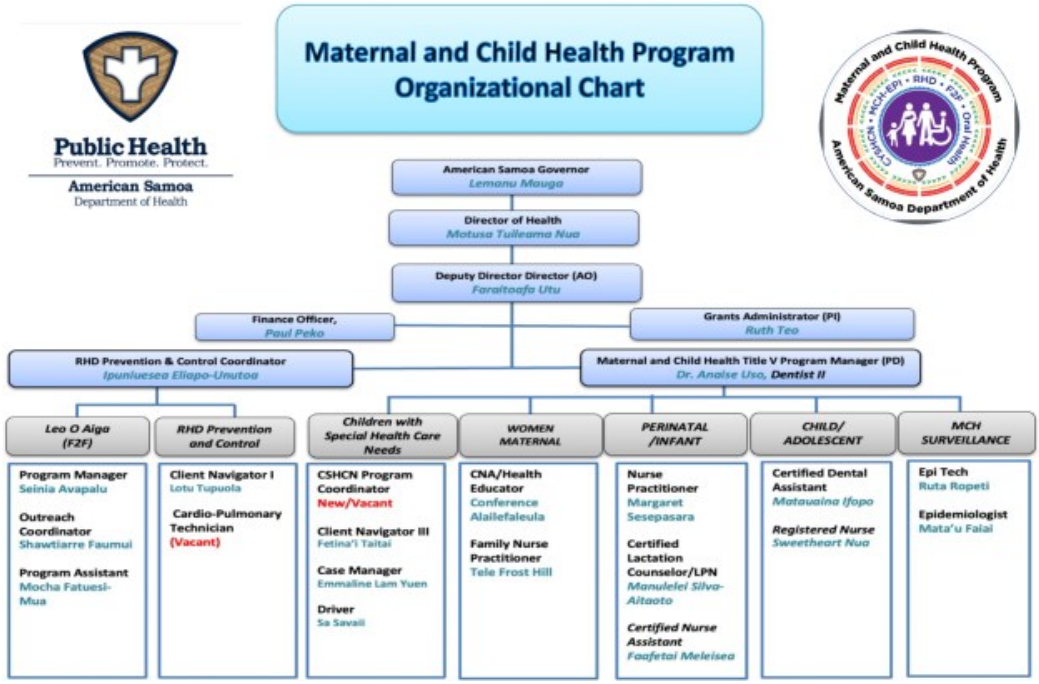
III.A. Executive Summary

III.A.1. Program Overview

PROGRAM OVERVIEW:

The American Samoa Maternal and Child Health (ASMCH) Program under the Department of Health receives funding from the federal Health Resources and Services Administration (HRSA) Title V Block Grant, towards improving the lives and overall health of women and children, including children and youth with special health care needs in the territory. ASMCH is currently under the leadership of the Deputy Director, who reports to the Director of Public Health. An organizational chart is displayed in Figure 1.

Figure 1: American Samoa MCH Program Organizational Chart:



Needs Assessment Findings:

The ASMCH Title V Program continues to use the block grant logic model to guide the development of the 5-year program plan. From the initial year of the 5-year cycle, the needs assessment process is strategically done to gather information leading to priority needs on all MCH populations. Throughout the year 2020, Title V program staff have been involved in various meetings, training, and informational discussions on issues that directly impact the health and wellness of women and children in the territory. These opportunities provide a means for Title V to continue monitoring changes, progress, and challenges that occur throughout the year on selected priorities. Stakeholders were given opportunities to provide feedback on selected program goals and objectives with reassurance of a continued process for annual review and revisions.

ASMCH Priority Needs and Emerging Needs:

POPULATION DOMAIN	AS MCH Priority Needs	NEW, REVISED OR CONTINUED PRIORITY NEED FOR THIS FIVE-YEAR REPORTING PERIOD		
		New	Revised	Continue
Women	1. Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.			X
Perinatal and Infants	2. Families are empowered to make educated choices about infant health and well-being.			X
Perinatal and Infants	3. Establish a Blood Spot Screening Program in American Samoa			X
Children	4. Developmentally appropriate care and services are available for all children.			X
Children	5. Reduce Acute Rheumatic Fever and Rheumatic Heart Disease.		X	
Adolescent	6. Communities and providers support adolescents' physical, mental and emotional health.			X
CYSHCN	7. Improve system of care for Children and Youth with Special Health Care Needs.			X
Cross-cutting	8. Establish a Centralized Health Database at the Department of Health.			X

The MCH Team and stakeholders identifies priority needs that are specific to American Samoa with distinct variations directly related to cultural, economic, and geographical challenges and expectations, but are very similar to the needs of women and children across the vast United States These needs range from improving healthcare early in a young woman's life, before, during, and after pregnancy, to ensuring best health outcomes for children from newborn to adulthood.

The Title V Program State Action Plan overall will generally remain as determined from the 2020 Needs Assessment process, with a few revisions due to the recent COVID-19 pandemic and its overall continued effect on the community and the healthcare system. Although American Samoa has been successful so far in remaining COVID free since the pandemic started, there are still numerous significant matters that have prompted some minor reconsiderations to the Action Plan for the remaining four years of this cycle. The State Action Plan will be revised accordingly to correspond with changes and challenges brought about with the COVID pandemic, as well as the input from Title V partners.

Some of these adjustments will address challenges women and children, as well as children and youth with special needs, have had to endure throughout the year and onward due to the pandemic. These challenges include access to preventive healthcare during "shut-down" mode among the entire community, having an appropriate system in place for families to access necessary services during a pandemic or an island-wide emergency evacuation plan that is adopted by the community as a whole. Due to COVID-19, ASMCH has also begun initiating concepts that will teach clients how to engage in utilizing telehealth as an option during these challenging times to ensure continuity in care and wellness.

The ASMCH team has reviewed its Strategic Plan and has made revisions to accommodate changes brought about with the current pandemic. These revisions were made possible to enable the program to attain "low hanging fruits" and continue to sustain a momentum in improving health for pregnant women and women in general, as well

as all children, adolescents, and those with special needs. These “low hanging fruits” are such things like strengthening partnerships with other existing programs in the community to address priority concerns in our strategic plan. For example, while the territory was diligent in keeping its borders closed to COVID infection during 2020, the rate of teen suicide in the island was becoming a crisis.

In the course of one month, a total of eight suicides among young teenagers was recorded. ASMCH sought for an AMCHP grant and applied, receiving funds to address suicide among teens and young adults in the territory. These funds afforded equipment to set up a suicide hotline that is now housed and operated under DOH. ASMCH also was able to purchase telehealth equipment for all high schools in the islands, both private and public, to connect at-risk students directly to available mental health professionals for counseling services. This has also engaged non-profit organizations who work with this age group to collaborate with the local Department of Education and Department of Health to improve mental & behavioral services across the island for young people contemplating suicide. To this day, all of ASMCH staff have been trained as operators for the suicide hotline and are confident to use this skill also in our daily work with our program clients.

At the start of COVID-19 vaccine efforts, help was needed to make reminder phone calls to folks who were due for their second dose, and the ASMCH team stayed after hours to assist in making these calls. While schedules for health centers were uncertain during a lengthy period in 2020, our family center partnered with another nonprofit, Parents of Children with Special Needs (PCSN), to provide computer courses for families of children with special needs so they can learn to create an email, use social media to connect and learn how to use zoom. These classes lasted for almost an entire year, and ASMCH was able to support these efforts as they were presented.

Majority of the MCH services occur within the community health centers (Prenatal, Well Child, Primary Care Clinics). With Title V funds, some clinicians who are nurses, dental assistants, health educators are fully funded by the MCH Program to provide services and support at these health centers. MCH client navigators and case managers often visit families at their homes or in the community to further determine how the program can support their health needs. The local health agency influences and supports Title V priorities by integrating existing programmatic goals and objectives into existing services, influencing larger outcomes and more successful results. An example would be having a family access both well child and prenatal services at the community health center. These services are supported by not only ASMCH, but clients also have access from other DOH programs such as Tobacco/Diabetes Program, Breast & Cervical Cancer Program, other NCD programs and of course FQHC overall. Each program targeting their own agenda and task while the family is able to access comprehensive care, a win-win situation for everyone involved.

Program Evaluation:

ASMCH gathers input from stakeholders and community participants on the work that is provided and supported for women and children, as well as children with special needs and their families. Quarterly reports are submitted to the DOH office for leadership to review and provide feedback on the progress of the program and how the public is served through our objectives and efforts. There is a strong connection between the ASMCH program and its non-profit organization partners in the community, where consistent discussions and meetings occur to evaluate efforts that target our specific populations. ASMCH also attends various meetings and training where primary healthcare providers are present and can share their feedback, request for specific support, and provide valuable insight into healthcare improvements for our women and children. These are various ways that the ASMCH use to evaluate the work we are tasked to do throughout the year.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

The ASDOH receives approximately $485,500.00 in Title V dollars annually to assure access to preventive and primary health care services for the required population groups of: (1) preventive and primary care services for pregnant women, mothers and infants; (2) preventive and primary care services for children; and (3) services for children with special health care needs (CSHCN). American Samoa Title V allocate a minimum of 30 percent of available funds to services for children with special health care needs, and a minimum of 30 percent of available funds to services for children and adolescents.

Together with State funds, and other additional federal funds, the Title V MCH block grant is used to address American Samoa's MCH priority needs, improve performance related to targeted MCH outcomes, and expand systems of care for the MCH and CSHCN populations. The ASMCH Title V funds compliment the State Plans in supporting healthcare for women and children by addressing gaps and priority needs which are not achieved by State funds or other federal dollars.

III.A.3. MCH Success Story

Children & Youth with Special Health Care Needs/Leo O Aiga Health Information Center

Success Story

Our client is a 22-year-old male who is diagnosed with Lesch Nyhan Syndrome. This client has been with the CYSHCN program since he was an infant. We have developed a strong relationship with him and his family, understanding the challenges and change this individual and his family has had to endure since his young life. He is wheelchair bound and has severe, self-injurious behaviors that prompt the family to use fabrics to "tie" him down so he is unable to harm himself. He is very alert and understands Samoan and English language, and able to respond appropriately. He spends all day every day in his home because he does not have a reliable chair to use.

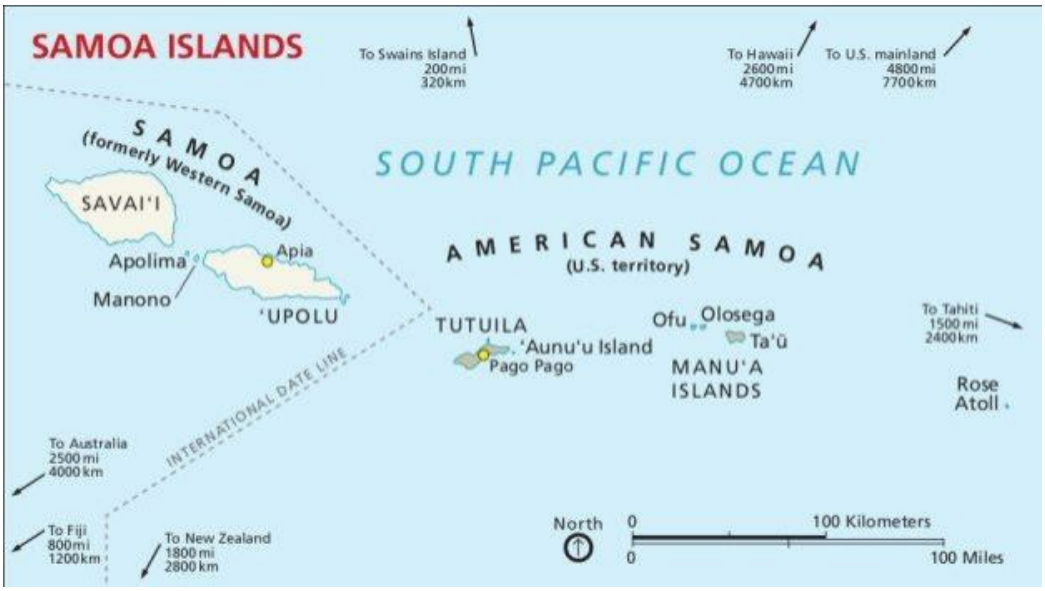
This client was using a chair from the time he was a student at SPED, this chair has become unsafe for him to use any further. Efforts were initiated by the ASMCH CYSHCN team as well as our Family Center staff to find a replacement wheelchair. We had learned that Medicaid was not able to finance this equipment request and so we reached to our outside partners. A parent organization for special needs joined our efforts to finance a new reliable wheelchair for this young gentleman so he can enjoy his community and have a meaningful life. Through this organization, donation requests were publicly announced, and the local radio station joined the efforts by conducting a radiothon for this effort. In less than a week, a sufficient amount was raised to purchase not one but two customized wheelchairs for this 22-year-old and another deserving individual facing the same dilemma.

A special ceremony was held at the ASMCH office which was live to the community to publicly express our gratitude as well as providing an opportunity for the family to thank the donors directly. Government leaders were present and were inspired to continue this effort for the community.

It is important to note in this story, as with many families who have a child with special needs, there are so many more issues other than acquiring durable medical equipment (DME). This individual and his family continue to need support and assistance with immigration paperwork, transportation, financial means, and community integration. ASMCH continues to provide all the support that is possible through our workforce and resources for this family and many others who are similar in such situations.
Meanwhile, this client is now able to utilize his wheelchair to go outside of his home, to access the community and to attend his medical appointments as scheduled. And his family reports he spends almost his entire day on his brand-new wheelchair as he loves it so much.

III.B. Overview of the State

Overview of State 2020



Geography: American Samoa is a self-governing territory of the United States and consists of a group of seven islands in the southern Pacific Ocean. It is located about half way between Hawaii and New Zealand south of the equator line. The total land area of American Samoa is approximately 76 square miles (200 square km). The main island of Tutuila, the largest island of the group, covers an area of 55 square miles (143 square km), just slightly larger than Washington DC. The center of Tutuila is called Pago Pago, the political, administrative, and commercial center of the Territory of American Samoa.

Aunu'u Island is one mile off the southeast tip of Tutuila (a 15-minute ferry ride), with a land mass of 0.6 square miles and a population of about 300 people. Sixty miles east of Tutuila is the Manu'a Island group (a 30-minute airplane ride or a 12-hour boat ride from Tutuila) that includes the volcanic islands of Ofu and Olosega, connected by a bridge, and the Island of Ta'u. These islands are sparsely populated, with a total 2010 Census population of 1,400 residents, and each village having a few hundred residents. The Swains Island is a privately-owned coral atoll located 214 miles north of Tutuila with approximately 1.25 square miles of land mass and a population less than 20 (2010 Census). Swains Islanders raise coconuts and grow bananas, taro, breadfruit and papaya, and supplement their diet with fish from outside of Swains' reef. Rose Island (coral atoll) lies 78 miles east of Ta`u with a landmass of 0.1 square miles, is uninhabited and is named a national monument.

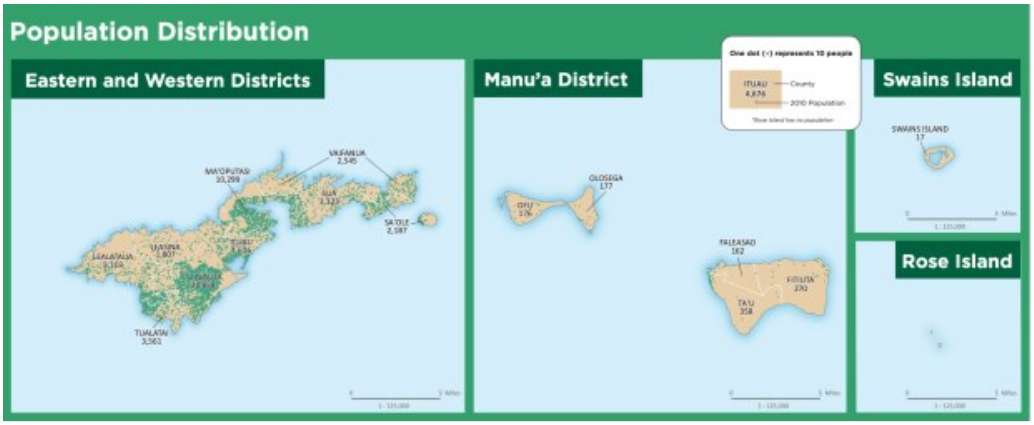
Geographically, Pago Pago has one of the best natural deep-water harbors in the South Pacific Ocean, sheltered by shape from rough seas and protected by peripheral mountains from high winds. American Samoa climate is typically hot, humid and rainy throughout the year, moderated by southeast trade winds. Maximum rainfall averages about 122 in (3,100mm) per year. Rainy season is also typically hurricane season, happening from November to April, while dry season occurs from May to October. Maximum temperatures range from upper 70’s to mid 90’s throughout the year.

Population: According to US Census 2020 for American Samoa, information released accounts for a total population count of 55,519.

Total Population

Eastern District	23,030
Manu'a District	1,143
Rose Island	0
Swains Island	17
Western District	31,329
American Samoa	**55,519**

Distribution districts are displayed in the following map by the US Census for American Samoa 2020.



American Samoa is divided into four geo-political districts: Western District, Eastern District, Manu`a District, and Swains Island District. The population distribution for these districts show that there are 31,329 residents (56.4%) in the Western District, 23, 030 residents (41.5%) in the Eastern District, 1,143 in the Manu`a District and 17 residents in the Swains Island District (2.1%). The age group of 25-54 years old has the highest percentage of the population at 37.49%, followed by 0-14 years old at 27.76%, then followed by the 15–24-year-olds with 18.16%, then followed by the 55–64-year-olds at 9.69%, and then finally with the age group of 65 and over at 6.9%.

Population Growth: Growth of the population has been estimated at -1.4%. This is evident in recorded numbers of birth & death rates. Birth rate is at 17.8 per one thousand while death rate is 5.9 per one thousand. total: 9.9 deaths/1,000 live births. Infant mortality rates are marked in males at 11.7 deaths per one thousand live births, and for females at 8 deaths per one thousand live births. Life expectancy for the total population is noted at 74.8 years.

Ethnicity: Of the population, 92.6 percent reported as Pacific Islander are native Samoans, 3.6 percent are Asian, 2.7 percent as mixed, 1.7 percent is of other origin. Although the majority of the population is consistent of native Samoans, more than two-fifths of the population were born outside of the territory, largely in the neighboring independent Samoa Island, with smaller proportions from the United States, other Pacific Islands, and Asia Countries.

Language: Most people are bilingual and can speak English and Samoan fluently. Samoan, a language closely related to Hawaiian and other Polynesian languages, is spoken natively by 9 percent of the people as well as the co-official language of the territory. While 80 percent speak English and Samoan, 2.4 percent speak Tongan, 2 percent speak Asian languages, and 2 percent speak other Pacific Islander languages. Tokelauan language is also spoken

in Swains Island. Literacy is calculated at 97 percent.

There are 9,349 households in American Samoa of which 8,706 (93.1%) are family households and 643 non-family households (householders living alone). Of the family households, 6,596 (70.6%) are married-couple families of which 5,261 are households with children under 18 years of age and 1,398 (15%) are female head of household of which 640 have children less than 18 years of age. Of the total households of all types, 7,598 (81.3%) are households with an individual under 18 years of age. In addition to the fact that the vast majority of the population of American Samoa is concentrated on one island, Tutuila, the residents of American Samoa are culturally a relatively homogeneous population.

Economic Environment: Traditionally, the local economy consisted of subsistence farming and fishing. In the 1970's and 1980's the influence of the U.S. mainland standard of living took a significant stronghold in local communities. Since then, the concept of sustenance living took a downward trend as young American Samoans left for military services, education, and better opportunities on the mainland. Presently, American Samoa has the highest rate of military enlistment of any U.S. state or territory including Pacific Military jurisdictions. With better opportunities came the potential to have enough money to provide for families back on the islands.

For the past 2 decades, major improvement in the cash economy was evidenced by significant increases in exported canned tuna products valuing at over $400 million annually, drawing more migrant families from neighboring islands such as the independent Samoa and Tonga. Tuna fishing and tuna processing plants were the backbone of the private sector, with canned tuna as the primary export. Since then, two Tuna companies have departed the island leaving Starkist Samoa as the only cannery operating in Tutuila, due to the U.S.-International trade agreements and expanded foreign competition, the loss of federal tax incentives, and the dramatic increase in the minimum wage that took effect in American Samoa 2008.

The territory experienced modest economic growth in 2014 and 2015, which was spurred, in part, by a large capital investment by Tri Marine International on the purchase and construction of facilities for processing and packaging locally harvested tuna. The cannery opened early in 2016, under the name Samoa Tuna Processors (STP). Competition from Asian-based canneries immediately put the company in a precarious position and processing operations permanently halted in late-2016. STP laid off at least 400 employees during the closure, which led to hundreds of additional job losses in related and support industries over the following year. Star-Kist Samoa Co., American Samoa's last remaining tuna processor, also faced setbacks in 2017. Availability of landed fish, along with a number of federally-mandated equipment upgrades, forced the company to temporarily halt operations for five weeks in the fourth quarter of 2017. The shutdown left thousands of employees without salaries to cover basic expenses and cost the local government more than half-a-million dollars in income tax revenues. The combined impact of the cannery closures contributed to a spike in the unemployment rate in the territory in 2017, from 10.5% in 2016 to 14.3%.

The recession may have extended into the following year, if not for a devastating storm that impacted much of American Samoa in February of 2018. By some estimates, Tropical Storm Gita caused as much as $186 million in direct and indirect damages across the territory. At least 50% of all individuals in the territory were faced with significant damage to real and/or personal property during the storm. Food, water, and other basic necessities were in high demand throughout the days and weeks that followed. During that time, automated teller machines were persistently low on cash supplies as the people of the territory scrambled to draw enough to cover immediate repair and replacement costs.

Ongoing disaster relief funding contributed to modest consumer and government spending increases in American Samoa in 2018 and through to 2019. Additionally, international relief agencies distributed pre-loaded gift cards to families and individuals that were most affected by the storm. Disaster relief funding has contributed to consumer

and government spending in 2018 and through to 2019. Once the immediate effects of the tropical storm diminished, so did many of the economic stimulus benefits.

The United States provides assistance to the American Samoa government, including funding the majority of its revenue. In fiscal year 2018, the American Samoa government's financial audit reported that U.S. federal grants provided approximately $150 million of $246 million in total American Samoa government revenue. Ranked by approximate grant expenditures, the largest federal grantors were the Departments of Health and Human Services ($43 million), Agriculture ($33 million), Interior ($30 million), Education ($28 million), Transportation ($18 million), and Homeland Security ($5 million).

American Samoa also benefited from recent strength in the broader US economy in 2018, driven primarily by strength in labor markets. With relatively low domestic unemployment rates and consumer inflation, wage growth seems to have finally taken hold in the US during 2018, which appears to have translated to accelerated spending by both households and private businesses.

Combined territorial and federal government spending in American Samoa is expected to have grown by 11.0% in 2018 and is projected to decrease by 2.8% in 2019 as the impact of project grants and disaster relief funds begin to dissipate. Government spending is then expected to increase by 0.8% in 2020, when hundreds of additional workers are hired for the decennial census. Following the completion of the survey, temporary Census employees will fall off of public payrolls and government spending will contract by an estimated 2.1% and 1.3% in 2021 and 2022, respectively.

The accelerated growth in government spending in the early years of this forecast, along with the swell in relief funds to individuals and families, is anticipated to have created as many as 500 jobs in the government and private sectors in 2018, lifting personal income by approximately $10.4 million that year. Personal consumption expenditures are forecast to grow by 1.3% in 2018, 1.4% in 2019, and 0.4% in 2020 before contracting by 1.9% in 2019.

According to the *Comprehensive Economic Development Strategy Report* for American Samoa 2018-2022, a SWOT analysis identified several strengths and weaknesses that have contributed to the economy of American Samoa. One noted weakness was the quality of healthcare, stating "The Lyndon B. Johnson Tropical Medical Center (LBJ) is the sole hospital in the territory. As a result, patients frequently experience long delays when seeking medical care. Of those surveyed, 33.3% identified quality of healthcare a weakness. There are only a small number of private health care practices located in the territory, mainly due to an inability of patients to afford the high cost of unsubsidized health care services. The Department of Health (ASG DOH) does operate five other Community Health Centers, which has helped to alleviate some of the strain on LBJ. The territory has also long struggled with securing and retaining high quality health care practitioners. This is due, in part, to the territory's remote location, the relatively heavy workload, inadequate funding, and uncompetitive wages.

The 2015 Household Income and Expenditures Survey also collected information on types of income and on regular, annual, and daily expenditures. American Samoa median household income is $22,000 compared to the US median of $52,000. About 42 percent (16,557) of all adults were working at a paid job in 2015. The largest industries in the territory were manufacturing (at 18.1 percent), public administration (17.8 percent), education (17.0 percent), retail trade (8.0 percent), health and social services (7.0) and construction (6.1). Similarly, the largest occupations were production (15.8 percent), office and administrative support (13.2 percent), and education (11.2 percent). About half the workers were in the private sector compared to about 45 percent who worked for the American Samoa Government.

Update on Economic Changes due to current Pandemic:

2019 Pre-Pandemic:

- Gita Disaster Relief Funding ended in September (Food Stamps)
- Gross Domestic Product (GDP) decreased by 1.4%
- Government spending decreased by 8.8%
- Exports decreased by 4.7%
- Private fixed investment decreased by 22.7% (decline in construction activity)
- Consumer spending increased by 3.0% (largely driven by healthcare purchases)

2020 COVID Pandemic

- $35 million allocation of COVID19 funding for the territory by March
    - Economic Impact Payments (Stimulus) ($130 million)
- Coronavirus Relief & Economic Security (CARES ACT of 2020)
- 28 million payroll protection program (PPP) US Small Business Bureau Loans
    - 75% loss of revenues for farmers due to closure of schools

2021 COVID Pandemic

- Over 1.4 billion allocated and received (still receiving) by the territory of American Samoa under the following 3 COVID19 laws:
    - CARES ACT
    - Consolidated Appropriation Act of 2021
    - American Rescue Plan Act (ARPA)

It should be noted that there was a significant increase in spending due to the stimulus payments to the government, private sector, and community members altogether. However, there were also delays in receiving items or cargo shipments were reduced by either air or sea due to the pandemic. Although concrete figures are not yet published to determine how these funds were spent, it is reasonable to expect that the following were possible due to this assistance:

- Repatriation Expenses of local residents who were stranded due to border closures (Airfares, hotel accommodations, meals, ground transportation, logistical costs, equipment, wages, etc.) both in Hawaii and American Samoa.
- Quarantine Housing to accommodate repatriated residents
- Public Facilities Improvements to coincide with pandemic recommendations
- Upgrades on hospital structure and equipment
- Public Service Announcements related to COVID preparations
- Emergency Preparedness Plans and Implementations
- Community Events to disseminate COVID information and increase awareness about COVID
- Vaccination Outreaches

Cultural and Social Environment: The Samoan culture plays a very significant role in the community and social context. Traditionally, the family and culture are of utmost importance to the people. The Samoan family or “aiga” has strong bonds and is a key factor in both service delivery and patient decision-making. Families make decisions together and often, the family as a group makes health decisions rather than as individuals.

Key members of the Samoan community are family leaders, cultural leaders, and church leaders. The Samoan cultural leaders are the "matai" or the chief of each respective clan or family. Land ownership and family dwellings are also tied directly to family, clan and matai titles where the land is communally owned by the family and under the stewardship/authority of the matai. The matai system provides an extension to the conventional or western idea of families, where any given family or clan includes several households or sections of a village. Respect and compliance for both the matai and/or family leaders such as parents and grandparents are paramount in Samoan society. Matai and family leaders are important members of the Samoan cultural and social environment.

Religion: Christianity is the foremost religion in American Samoa, reported to be 98.3 percent of the population. Churches are embraced as an important component of society. Church leaders are revered in all social, cultural and professional settings. Church groups are among the most organized and well attended non-governmental organizations in the community. Most families and individuals are active participants in a church organization of some fashion. Health promotions and outreach activities are often delivered in religious settings as it reaches the majority of people.

Way of Life: Samoans live a communal way of life, participating in activities collectively. In a Samoan village, each 'aiga' or family live on family or communal land, often next to each other. Though each family within the family may live in their own housing structure, the family is one – everyone works the same land, cook together, eat at one 'fale ai' or family dinner house, pray in one home together and are only separated by night to rest. This continues to be a practice today in many Samoan communities.

These key factors play an important role in health planning. It is well understood in the health community that any service provided at any level must take into consideration the cultural and social environment of the family. Many of the services delivered at the community level are designed to be family-friendly, culturally appropriate, or religiously acceptable as most people in American Samoa are active participants in one or all of these groups.

Health Care System: Under the American Samoa legislative code all residents are entitled to free medical care. Therefore, all health care services are heavily subsidized by the government and delivered at little or minimal cost to residents. Services are administered through the Department of Health and the American Samoa Medical Center Authority (LBJ Hospital).

The relationship between the sole local hospital and the Department of Health is one of strengths and weaknesses. The LBJ hospital is assigned to address acute hospital care to the entire island, with support services that enhance diagnostics and treatment to those who seek care from this facility. DOH serves the community through the community-based health centers spread across the islands, along with preventive programs that are federally funded with local matching requirements for sustainability of services. These two healthcare entities deliver services in a range that complements one another. For instance, Community Health Centers provide prenatal care free of charge for all pregnant mothers, with the exception of those with high-risk pregnancies who would be referred to the hospital for follow up care throughout their entire pregnancy. By the 3rd trimester, the pregnant mother will be referred from Community Health Clinics to the LBJ hospital for continued care until after giving birth. Preventive and primary care services are the sole responsibilities of the Health Department while the LBJ hospital provides acute care.

The American Samoa Medical Center Authority (ASMCA), the only hospital in American Samoa, provides all acute medical services and includes outpatient clinics as well as inpatient hospital care. The ASMCA provides outpatient care at the Emergency Room, Primary Care Clinic, Pediatric Clinic, Obstetrics and Gynecology Clinic, Surgical Clinic, Orthopedic Clinic, Medical Clinic, Ear Nose Throat Clinic, Dialysis Clinic, Psychiatry Clinic, Dental Clinic, Physical Therapy Clinic, and the Eye Clinic. The inpatient services include 128 patient beds in six wards: Labor and Delivery, Nursery, Maternity, Internal Medicine, Surgical, Intensive Care, and Psychiatry.

The LBJ Tropical Medical Center (LBJ TMC) is a 150-bed general acute care hospital, with an approximate footprint of 150,000 square feet, constructed into six (6) separate linear buildings connected by two primary corridors bisecting each, in a grid pattern. The facility was originally constructed in the mid 1960's and attained full operation in 1968. The facility is a single-story concrete bent frame, sloped roof and wood framed structure which has undergone a number of minor renovations over the years.

The facility is certainly approaching the end of its serviceable life cycle (50 years). Currently, 41 percent of the facility has been renovated to meet CMS standards. Upon completion of the current labor/delivery nursery expansion and renovation project, LBJ facility will be 65 percent renovated. Administrators of the local hospital continue to face the challenge of increased outpatient visits and high inpatient census. One of the solutions that they are presently exploring is a new 200-bed hospital to accommodate increase in population, as well as inpatient and outpatient visits. Space in the present location is severely limited, and LBJ is unable to expand the existing building which, in turn, limits services.

In the last five years, ASMCA has extended its Dialysis Unit to accommodate 32 chairs, providing much needed services to well over 200 patients requiring dialysis. Most recently, a private-owned dialysis clinic opened its doors to the public. The latest survey reported data that shows 24,623 patients visited the hospital's emergency room. The hospital had a total of 3,937 admissions. Its physicians performed 907 inpatient and 2,521 outpatient surgeries. The ASMCA also provides all laboratory, diagnostic imaging, and pharmacy services for the entire population. The ASMCA operates as a semi-autonomous agency of the government and is governed by a board of directors whose membership is subject to legislative approval.

The Department of Health is responsible for preventive and outreach services to the community. The Department of Health delivers primary care services through the Federally Qualified Health Centers (FQHC). There is one FQHC situated on the West side (heavily populated area) called Tafuna Family Health Center (TFHC). In 2009, TFHC added two new access points to its services, which included Leone clinic on the western tip of the island, and Amouli clinic on the eastern tip of the island. There are 5 satellite clinics spread geographically throughout the island including one in Ta'u and Ofu, of the Manu'a Islands. A newly renovated primary health clinic began its services in mid 2017, located across the LBJ Tropical Medical Center. This clinic combines services for employment physicals, school athletic clearances, Tuberculosis screenings, RHD echo screening, and Flu shot campaigns. DOH is continually recruiting additional providers to operate this clinic as only one provider is currently stationed at this site.

Since the Zika outbreak in 2016, federal funding assistance enabled a satellite pharmacy to open and operate from TFHC, as well as a laboratory to conduct testing for CHC patients. In the past years, nurses mainly managed Manu'a health clinics, with occasional visits from an available physician. With continued recruitment of doctors for CHC in the past year, the Manu'a health clinics have been able to entertain a doctor who lives on site and provides services for the Manu'a population. Also, through the MCH Zika grant, telehealth equipment has been installed in the Ta'u health center, as well as Amouli and Leone health centers, to allow connections during telemedicine and telehealth sessions with US based partners.

The Department of Health is also responsible for infectious and chronic disease surveillance and prevention, community nursing services, environmental health, immunization, Public Health Emergency Preparedness (PHEP), Comprehensive Cancer Control Program (CCCP), HIV and STD screening, early intervention, newborn hearing screening, as well as MCH Program services and the Maternal Infant Early Childhood Home-visiting (MIECHV) Program.

In November of 2019, the territory raised a response to the measles outbreak which originated from the neighboring independent Samoa Island, and eventually seen in the territory. DOH led efforts to enforce herd immunity assuring

measles infection were minimal and in a controlled situation. Following the measles outbreak was the COVID19 pandemic, which contributed to the sharp increase of emergency hires to assist with COVID operations led by the Health Department. To date, the health department workforce contains more than 300 employees, most of which are laymen.

A Medicaid Program exists in American Samoa, operating directly under the Governor's office. American Samoa's Medicaid program was established in 1983. It is a 100% fee-for-service delivery system with one hospital servicing the territory. There are no deductibles or copayments under the American Samoa Medicaid program, however there are some fees charged by the hospital located in American Samoa. Through Section 1108 of the Social Security Act (SSA), each territory is provided base funding to serve their Medicaid populations.

For the period of July 1, 2011 through September 30, 2019, Section 2005 of the Affordable Care Act provided an additional $181,307,628 in Medicaid funding to American Samoa. These monies have allowed the Medicaid program to support an off-island referral process for cases that cannot be addressed in American Samoa. These cases are directly referred to New Zealand to further care under the sponsorship of the Medicaid program. Most recently, American Samoa has been allowed to use Medicaid funds to pay for healthcare services in the state of Hawaii. Hence all outbound flights since June of 2020 have been chartered by Medicaid to transport local patients who require services that are otherwise available locally. Some of these cases include children who require heart valve replacement surgeries due to complications of Rheumatic Heart Disease and babies born with congenital defects.

Eligibility in American Samoa differs from eligibility in the states. American Samoa does not have a TANF or SSI program and does not determine eligibility on an individual basis. Rather, the territory uses a system of presumed eligibility. Each year the percentage of the population below 200% of the poverty level is estimated and, after CMS approval of the estimate, CMS pays expenditures for Medicaid based on that percentage. There are plans in the very near future to begin individual eligibility enrollment for Medicaid funding.

American Samoa was awarded $16,510,330 million for its Medicaid program in lieu of establishing a health marketplace. American Samoa must exhaust its Affordable Care Act (Section 2005) allotment prior to using these funds. Moreover, the FQHC's became eligible for Medicaid reimbursement for services provided through an amendment in February 2017. Due to this eligibility, FQHC's were able to offer care without a cost to the public. An additional amendment proposed coverage and reimbursement of emergency and certain other medical services furnished by off-island and out-of-country providers became effective April 1, 2017. Due to the current pandemic and the flow of federal funds into the territory, both LBJ and the DOH clinics have been able to serve the community without imposing a fee upfront except for emergency services.

Department of Human and Social Services (DHSS) is the Territory's Single State Agency for Substance Abuse Prevention and Treatment. It also serves as the State Mental Health Authority and is the Governor-designated lead agency for Child Welfare Services and Social Services and is the lead agency on underage drinking. This 100% federally funded agency directs four (4) core agencies, including: 1) Social Services; 2) Women, Infants and Children (WIC); 3) Nutrition Assistance Program (Food Stamps); and 4) the Vocational Rehabilitation Division. DHSS provides substance abuse prevention and outpatient counseling to more than 150 families each year, as well as mental health services, 24-hour emergency shelter services and crisis hotline, shelter program for the homeless, victims of crime advocacy, crisis intervention, family support services and subsidized child care for low-income working families.

DHSS and DOH often collaborate in efforts that combine the social and health aspects of the community, respectively. The MCH Title V program partners with DHSS annually for breastfeeding, nutrition, behavioral health, child care, oral health, and surveillance efforts. DHSS primarily conducts the SBIRT (Screening, Brief Intervention,

and Referral to Treatment) tool to identify, reduce, and prevent the use, abuse, and dependence on alcohol and illicit drugs. Most recently, a 988-suicide hotline was implemented to address the rising number of teen suicide in the territory. Both DOH and DHSS employees work around the clock to man these lines while also performing their daily jobs.

There is a Veterans Affairs Clinic in American Samoa, which caters to veterans and military reservists. The clinic has less than five doctors, and provides outpatient services only during regular business hours five days a week. The VA clinic also accesses laboratory, pharmacy, dental and radiology services at the ASMCA. Other private specialized clinics in the community owned by Samoans include services such as Optometry, Primary Care, Sleep Care and Dental operated by an Orthodontist.

Other types of health-related entities also exist within the system of care for American Samoa. These include the following:

- Hope House - the only nursing home-type of setting on island, housing the elderly and children with severe disabilities
- Alliance for Families – providing support services for victims of domestic abuse and violence, shelter for families in difficult situations, and workshops/educational sessions on community-based services
- Intersections – is a 501 c 3 not-for-profit organization that has been creating opportunities for change among children and families since 2002. Intersections provides intervention and prevention services that empower young people to become successful in making positive choices, promote healthy living, and foster social responsibility
- EPIC - Empowering Pacific Island Communities is a non-profit organization that receives federal funds to address various issues in the community such as sexual assault, behavioral and mental health, community reintegration, trauma counseling and advocacy.

It is also necessary to comment on the Department of Youth and Women's Affairs (DYWA) under the American Samoa Government. DYWA conducts numerous programs throughout the year, targeting adolescents, youth, and women and includes the Department of Health in its efforts. Such programs address critical issues that improve autonomy and skills that are applicable to life in general for all women, adolescents, and youth. Through this collaboration, MCH participates to deliver relevant health education and promotion topics that are vital to their development and well-being.

MCH also works extensively with nonprofit organizations (NGOs) and the business community to reach goals that aim to improve the health of women and children in American Samoa. Local chapters of organizations such as the Rotary club, the Lions club, and the Shriners provide financial and humanitarian support to assist in health efforts such as vision & hearing, cardiovascular, and Orthopedic needs. The Intersections Program and EPIC are non-profit groups that focus on Adolescent Health and conduct sexual abstinence education and peer mentoring groups. The Paramount Construction Company has continuously donated financial assistance to support the annual Cardiology clinic for children with Rheumatic Heart Disease for the past five years. Other locally owned businesses have contributed to Health events that cater to the health of women and children.

MCH intends continuing collaborations with its valuable stakeholders to achieve priorities that improve the health and wellbeing of all women and children in American Samoa

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Ongoing Needs Assessment Activities
In August 2020, American Samoa concluded an extensive five-year needs assessment that led to the selection of the state MCH priorities and development of the MCH Action Plan. The full write-up of the process and findings of that needs assessment is available in the FY2021 application. Since summer 2020, there were several additional needs assessment activities that were conducted to monitor ongoing changes to health status and public health systems in American Samoa.

Collaborating with the DOH Behavioral Health Services Division and its partners to mitigate the rise in Suicide rates was a priority. MCH Title V assessed what was needed and reached out to AMCHP to apply for a Telehealth Grant that would assist with training, acquiring technology equipment and electronics, and improve access to affordable wifi. The application was approved and funded. Title V is actively collaborating with NGO's EPIC and Intersections Inc. to assist with school screenings, education and disseminating PSAs. Title V is also assisting with operating the 988 Suicide Prevention Lifeline afterhours but now would need funding for sustainability.

Over the course of 2020, ASMCH Title V continued to monitor the impact of the Measle outbreak and the COVID-19 pandemic on MCH services and outcomes. Many services had to be centralized at Tafuna CHC because outer clinics and staff were deployed to vaccination PODs for MMR vaccinations. This is currently happening for the COVID-19 vaccinations. This resulted in overall decrease of clinical service rates including medical, prenatal and dental visits. These data reports are included in Form 10 and Population Domain Narrative sections.

Stakeholder involvement

ASMCH had to be strategic this year in obtaining feedback from stakeholders. Due to the ongoing public health emergencies American Samoa faced in 2020, small groups meetings via zoom and face to face meetings for interviews were carried out. After the Needs Assessment were finalized and submitted, it was a challenge to find time for ongoing stakeholders' meeting. Title V had to maximize various partnership meetings for planning and community outreach activities to share health findings and discuss strategies and ESMs. Such meetings included:

1. Protect As One Festival with Chambers of Commerce members
2. Planning meetings with DOE to boost vaccinations
3. COVID-19 Vaccination Working Group weekly meetings
4. Unified Health Command weekly meetings
5. CMEs with medical staff
6. Weekly DOH Key Leaders Meeting

Changes in Health Status

Women's/Maternal Health: For the Data Trend 2015-2019, the percentage of pregnant women giving birth annually decreased by 25%. The number of females in the reproductive/child-bearing age group (ages 18-44) was 9496 representing 18.9% of the total population in 2019. Maternal Mortality continues to be zero 2015 - 2018 but we have yet to receive the rate for 2019 – 2020. While monitoring postpartum women's data, it was obvious that those who were accessing early prenatal in their first trimester did not necessarily mean they were receiving adequate prenatal care. Tafuna prenatal care was not always consistent in opening due to lack of provider and hence not all women were consistently being seen by a provider when they showed up for their check-up appointments. Definition for first prenatal care visit at the CHC level may be different from OBGYN Clinic at the Hospital.

Perinatal/Infant Health: Preterm births have gradually decreased in the past 6 years, from 9.14 per 1000 livebirths in 2014 to 5.92 per 1000 livebirths in 2019. Number of pregnant women have also been decreasing in the past five years. Approximately 80% of babies are born with normal weight and only 4% are born with low birth weight. There is obvious decrease in 2020 but it is not yet determined if its due to COVID-19 restrictions.

Child Health: High immunization coverage of routine vaccinations like the measles, mumps and rubella (MMR) is a strength for the child health MCH population domain in American Samoa. This was evident during the recent measles outbreak in American Samoa from November 2019 to March 2020. The 1st MMR dose for school age children (both public and private schools) and children in childcare services at 12 months and older, was estimated to be at 99.5%. In addition, 2nd MMR dose coverage for the same group was estimated to be at 99.5%. For the measles outbreak situation in American Samoa, a total of 16 laboratory confirmed measles cases and 0 deaths were recorded. However, the measles outbreak situation in neighboring Samoa was unfortunate. A total of 5,707 measles cases and 83 deaths (~80% among children less than age 5 years) was documented. WHO and UNICEF estimated MMR coverage in Samoa among young children to dramatically decrease from 74% in 2017 to 34% in 2018. The low MMR vaccination coverage in 2018 is largely attributed to the deaths of 2 infants who were mistakenly injected with the wrong MMR vaccine mixture.

Adolescent Health: Bullying and suicide have been shown to be significant behavioral health among adolescents in American Samoa according to the YRBBS data. Adolescents reported bullying on school property has increased from 25% in 2011 to 30% in 2015. Furthermore, there is an increasing number of adolescents who reported to have attempted suicide from 20% in 2007 to 25% in 2015. Suicide rates have yet to be finalized for 2019 – 2020 but there were definitely a rise in cases in 2020. This is why MCH Title V staff were deployed to assist the Suicide Prevention Initiative spearheaded by the DOH Behavioral Health Services.

Children and Youth with Special Health Care Needs: MCH Title V continues to provide care coordination services to CYSHCN. Appointment reminders for medical checkups and immunization, transportation and transition services. All children are Medicaid eligible hence receives free medical care at the LBJ Hospital and Community Health Centers. There are still challenges with ensuring SYSHCN have access to affordable and appropriate durable medical equipment because they are not readily available on island. An example is not only ensuring all children needing appropriate wheelchairs have them but also ensuring homes have accessible sidewalks, walkways and ramps their homes to the main roads.

Changes in Title V Capacity/Structure:

Since the submission of the Needs Assessment in 2020, the MCH Epidemiologist moved to the Territorial epidemiology Office to assist with the COVID-19 Surveillance and Operations. Most recently, the MCH Epidemiologist left off-island on August 12, 2021, to pursue her Public Health doctorate program at Yale University. She will be away for four years. It will take some time to hire another qualified MCH Epidemiologist. In the meantime, Title V staff who are also Epi Tech Certified will be overseeing MCH Epi Surveillance, analysis and reporting and working closely with Territorial Epidemiologist Dr. Aifili Tufa to validate data reports.

Emerging Public Health Issues and Future Needs Assessment Activities:

The AS Title V Program will continue to collaborate with the Public Health Surveillance Office to monitor the long-term impact of the COVID-19 pandemic among its MCH population. To date, American Samoa is still COVID free, but the travel restrictions, shortage of staff and clinic hours of operations will continue to have a negative impact on utilization of services and early prenatal care. ASMCH will continue to play an active role in the COVID-19 vaccinations to

reach the territory's target of 80% coverage for all AS residents. American Samoa will continue to assist Behavioral Health with promoting Suicide Prevention Initiative and also collaborate with EPIC and Intersections Inc to promote outreach activities for children and adolescents.

Future needs assessment activities are outlined in the Cross-cutting/System Building Domain application section. In FFY 2022, ASMCH will be conducting a more in-depth needs assessment pertaining to the actual number of CYSHCN as recommended in the FY2021 grant review summary statement. Part of this assessment will also be in-depth to determine how many needing transition services actually received them.

Based on the FY2021 Grant Review, American Samoa Title V Program was encouraged to collaborate with the Department of Education to develop methods to capture CYSHCN data among school-aged children and to develop upstream approaches to encourage the incorporation of developmental screening into school-based programs and pediatric care.

The American Samoa Title V MCH Program will also standardize data sources and reporting process for measures, in order to properly track and report on trends, over time.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Process Description

Introduction

Maternal Child Health Bureau (MCHB) is a division of the Human Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. MCHB awardees include all states, territories and freely associated states. The American Samoa MCH Title V Program is part of the American Samoa Department of Health. Each year, MCH awardees like American Samoa submit an Annual Report from the previous fiscal year and Application for the next fiscal year. In addition, MCHB awardees are mandated by law (Section 505a of the Title V Social Security Act) to submit a Comprehensive Needs Assessment every 5 years. The last MCH Title V Needs Assessment was submitted by awardees in 2015, and therefore the next MCH Title V Needs Assessment is due in 2020.

Goals

The American Samoa MCH Title V Needs Assessment was based on the following goals: review MCH population needs, examine capacity to address needs, identify MCH priorities, develop strategies to address priorities, select measures to monitor progress and set targets. Each MCH Title V Program is divided into 5 main MCH population domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and Children with Special Healthcare Needs (CSHCN). Needs for each of the MCH population domains were
reviewed in the AS MCH Title V Needs Assessment. American Samoa's island wide capacity was then examined if it will be able to fully address needs of the MCH population domains reviewed. Since each MCH Title V awardee were limited to 7-10 priorities, needs for the MCH population were identified and selected as priorities for the upcoming 5-year cycle. Once the MCH priorities were determined, strategies to address MCH priorities were developed. Measures from the National Performance Measure (NPM) Framework was selected to monitor the progress when addressing MCH priorities. Finally, targets were set and activities were identified to accomplish targets.

Framework

The MCH Block Grant Needs Assessment Conceptual Framework in addition to the Association of Maternal and Child Health Program (AMCHP) MCH Needs Assessment Toolkit were utilized to conduct the AS Title V Needs Assessment. The MCH Title V Block Grant Conceptual Framework was a 9-step process which served as a checklist during the ongoing Needs Assessment process. Steps of the MCH Conceptual Framework in no particular order were as follows: engage stakeholders, assess needs and identify outcomes, examine strengths and capacity, select priorities, set performance objectives, develop action plan, seek and allocate resources, monitor progress and report back to stakeholders. The AMCHP MCH Needs Assessment Toolkit included ready, set and go resources. The Ready resources provided an overview of the MCH Title V Needs Assessment. The Set resources provided details for the MCH Title V Needs Assessment Conceptual Framework. The Go resources provided examples from states and jurisdictions for the need's assessment.

Stakeholder involvement

Ideally, the MCH program planned to meet at least 4 times a year to discuss priority needs. But this past year was a little different due to the measles outbreak. Although meetings were canceled, we still worked together with our stakeholders to try and keep American Samoa measles free. We partnered up with DOE and LBJ to help get all the children and adults vaccinated. It was a coordinated effort that although we had 16 confirmed cases on island, we had no deaths. Our stakeholders met and worked together to come up with ways to help get everyone vaccinated. We did however manage to meet with them individually. We interviewed them and we put all the information we collected. Thankfully, we were able to host one meeting with everyone and presented our findings. We prioritized our needs for each population domain and everyone was excited to see what the MCH program will do for the next 5 years.

Quantitative & Qualitative Methods

The State System Development Initiative (SSDI) Jurisdiction Minimum Dataset was a method used by the AS MCH Title V program to provide quantitative data on selecting priorities for the AS MCH population domains. The SSDI dataset included the following indicators: teen pregnancy (15-19 years), low birth weights (<1500 grams and 2500 grams) , preterm births (<32 weeks and <37 weeks gestation), infant mortality (< 1 year), child mortality (1-9 years), adolescent mortality (10-19 years), adolescent suicide (15- 19 years), breastfeeding (ever breastfed and exclusive), risk behavior (female chlamydia 15-19 years), CSHCN with adequate insurance, immunization (full schedule for 19-35 months), and WIC BMI (2-4 years overweight and obese).

Qualitative methods utilized for the MCH Title V Needs Assessment were key informant interviews, focus groups and a stakeholder meeting. Since the MCH Title V Program and the Maternal Infant Early Childhood Home Visiting (MIECHV) Program share most of the same stakeholders, key informant interviews and focus groups for both needs assessments were conducted together. For the key informant interviews, each stakeholder was interviewed individually so they would be confident in expressing needs and gaps in each of the MCH population domains to be addressed in the next 5-year cycle. Focus groups were conducted by MCH population domains: women/maternal health, perinatal/infant health, child health, adolescent health and CSHCN. Information collected from the key informant interviews were grouped together as talking

points for the focus groups. The overall stakeholder's meeting was the final part of the qualitative method for the MCH Title V Needs Assessment, where stakeholders came together and discussed as whole priorities to be set for the MCH population of American Samoa.

Data sources

SILAS: Share Integrate Link American Samoa

SILAS is a registry that Helping Hands, Part C and Helping Babies hear program use to store and share data with other partners within the Department of Health. It includes family demographics, where they live, contact information, program progress notes and so much more. MCH was able to partner up with the Helping Babies Hear (HBH) program to get a correct count of all the babies born every year. MCH used to go to the nursery to collect this data, but after learning we are collecting the same information, it was more ideal for HBH to collect this data to eliminate the duplication of work. Information such as hospital number, weight, height, mother of the baby, hearing test results etc. are collected and is given to the MCH epidemiologist to clean and analyze for program reports.

Postpartum & Newborn Kotelchuck cards

Postpartum & Newborn Kotelchuck cards are collected by the MCH health educators from the Nursery and the maternity clinic. These cards consist the newborns, spontaneous abortions and stillbirths outside and inside the hospital. All information regarding the newborn and mother are included. From demographics to gestational age to breastfeeding, all that information is on the cards. And just like the data from SILAS, all the information is downloaded and given to the MCH epidemiologist to analyze and cross check with the data from SILAS to see if there is any missing information.

DHSS Women, Infants and Children WIC program

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), is a federally funded program which provides American Samoa residents with nourishing supplemental foods, nutrition education, breastfeeding promotion and health and social service referrals. The participants of WIC are either pregnant, breastfeeding, or postpartum women, infants or children under age five who meet income guidelines and have a medical or nutritional risk. MCH mainly uses this data to check for breastfeeding data. Every year, we collaborate with the WIC program to promote breastfeeding and in return we share information that both programs have collected throughout the year regarding breastfeeding.

WEBIZ: American Samoa Immunization Registry

WEBIZ is a web-based data system that stores information regarding every person's immunizations records. MCH uses data from WebIz to see how many children are up to date with their immunizations and what percentage of kids that still need their immunizations shots updated. With the recent measles outbreak, having this web-based system made it easy for nurses and doctors to keep track of shots given and how many more shots needed. Our MCH epi was able to spearhead the measles outbreak surveillance and having this web-based system made it easy for everyone to dump this information. She then analyzed the disseminated information to our leader so they can make more informed decisions.

Youth Risk Behavior Surveillance System (YRBSS)

Youth the Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults. Behaviors that contribute to unintentional injuries and violence, STDs, unhealthy eating habits etc. This survey is self-reported and all information is recorded and shared with the MCH epi to analyze and report on its findings. It can be a national school-based or local survey conducted by state, territory and local education and health agencies and tribal governments.

NVSS: National Vital Statistics System

The NVSS provides the most complete data on births and deaths in the US and its territories. Birth data helps track important demographics and health trends. Deaths data are helpful because it collects the most comprehensive information such as the causes of death. Fetal Deaths data can help identify pregnancy risks and improve the health of mothers and babies. This data is mandated by Federal law to be reported each year. The MCH epi analyzes this data and informs the leaders on what MCH should focus on the coming year and make that a priority.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

MCH Population Health Status

Women/Maternal Health

a. Summary of strength

During 2015-2019, the percentage of pregnant women giving birth annually decreased by 25%. The number of females in the reproductive/child-bearing age group (ages 18-44) was 9496 representing 18.9% of the total population in 2019.

Another strength identified during the Needs Assessment are availability of preventive health services women can access. They include the following:

- DOH Women's Clinic (Tafuna, Leone, Amouli)
- Breast and Cervical Cancer Screening
- HIV/STD Screening
- CHC Primary Care Clinics to screen for Non-Communiable Diseases
- WIC services
- LBJ Hospital OBGYN
- Title X Family Planning and CHC Family Planning
- American Samoa Alliance against Domestic & Sexual Violence
- Pae ma le Auli
- Catholic Social Services
- Women Faith-based Organizations
- Village Tinifu

b. **Health Priority 1: Women should have access to and receive coordinated, comprehensive services before, during and after pregnancy**.
According to the recent 2018 American Samoa Adult Hybrid Survey, 54.8% of adults self- reported that they received a medical check-up in the past year. Compared to the national rate of 70.4%, American Samoa's adult population perspective of prioritizing annual wellness visits is very poor. Chronic conditions continue to be very high among the adult population despite reporting a decreased rate of smoking, alcohol use and eating more fruits and vegetables compared to the American Samoa STEPS NCD Survey back in 2004. Overweight and Obesity remains prevalent among adults, with 82.7% of women ages 18 and older are obese (Figure 5).

In the 2019 ASMCH Jurisdictional Survey, 47% of women received a medical check-up in the last year. This percentage is even lower compared to the Hybrid Survey.

American Samoa's Title V first health priority was generated based on the top three health priorities identified for Women/Maternal Health Population. They were:

1. ***Provider shortage & competencies***

Clinic	Tafuna CHC	Leone CHC	Amouli CHC*	LBJ OBGYN	Manu'a Clinics
No. of Providers	1 Physician	1 MCH PN*	1 MCH PN*	7 Physicians	0 Prenatal Provider
Dates Clinic is done	Monday - Friday	Wednesdays Only	Thursdays Only	Monday - Friday	N/A

* Same MCH PN serving both Leone and Amouli.

2. ***Utilization of medical and mental services are lacking***
    - NCD (include weight management) and STD Screening
    - Preconception Health
    - Domestic violence (positive marriage counseling)
    - Healthy relationships (mental health)

3. ***Decrease in accessing early prenatal care***

Year	1st Trimester	Percent (%)	2nd Trimester	Percent (%)	3rd Trimester	Percent (%)
2017	311	34.1	185	20.3	75	8.2
2018	582	43.3	236	17.6	107	8.0
2019	612	46.7	274	20.9	118	9.0

According to CHC UDS, there is an increase in women who begins prenatal care at first trimester from year 2017 to 2019. There are also more pregnant women coming in at first trimester compared to second and third.

This findings from ASCHC UDS contradicts data collected from Maternity Ward Postpartum Cards. There is an obvious decrease in the percentage of pregnant women beginning their prenatal care in their first trimester by 1.8%, from 37.7% in 2017 to 35.9% in 2019. Compared to the 77% at the national level, this is very low. Compared to other USAPI, it's still low, with Guam at 70% and CNMI at 45%.

Regardless of the differences in percentages it is still low in comparison to the national rates.

2. **Challenges and gaps**

During focus groups and key-informant interviews, some of the challenges and gaps identified were:

- Lack of qualified, medical providers at women's clinics that can do both Obstetrics and Gynecology at DOH. Both providers at DOH see low risk pregnant women. One does Gynecology only while the other does both. Current ultrasound machine is not working so all women are send to LBJ for this purpose and to determine Expected Due Date etc.
- Low rates of women receiving an annual medical check-up
- Lack of empathy and good communication skills between providers and patients
- Ultrasounds not available for pregnant women at women's clinic at DOH
- Lack of committed provider for BCCP, STI and TB. Nurse can screen but cannot diagnose and consult.
- Only Tafuna Women's Clinic provide routine STD screening at pregnancy. LBJ only screen for Chlamydia if under 21 and a pap smear at 21 and over.

3. **Current efforts to address health needs**

- The primary care provider for Women's Clinic at Tafuna CHC has been stranded in Fiji. MCH Nurse Practitioner Tele Hill stepped in to serve these women but then is not consistent with seeing pregnant women at Leone. Amouli clinic has been closed for more than nine months. Pregnant women who reside in far East villages have to seek care at the LBJ Hospital OBGYN clinic.
- Health promotions utilizing social media are ongoing. DOH programs utilizes community outreach education and health fairs (CHC Week, Breastfeeding Week, Immunization Outreach etc.) to promote available services for women.
- Daily radio PSA are ongoing, informing the public of COVID-related preventive measures and clinics open to serve the community.
- CHC continue to provide after-hour clinics on Tuesdays and Thursdays from 4pm to 8pm to boost STD, BCC and Non-Communicable Disease screening, monitoring, management and referrals.

4. **Opportunities for improvement**

- Collaborate with all Prenatal Providers and supporting programs (BCCP, MEICHV, NCD, Intersections Inc., WIC, CHC Primary Care Providers) to promote early prenatal care services.
- Provide public service announcement videos and mass media campaign to promote pregnant women seeking early prenatal care.
- Ensure all health education materials and resources (Becoming a Mom curriculum) are translated appropriately and standardized across all prenatal clinics.
- Ensure all clients understand each session by having a pre and post-test to evaluate efficacy of the materials.
- Have appropriate handouts or reminders of each health education topic.
- Utilize peer groups, social media and social networks for women (village Tinifu and church groups) to promote and support, Breast and Cervical Cancer screening program.
- Formulate and disseminate a women check-up passport to improve tracking and monitoring of age appropriate visits

and screening appointments.
- Implement Women's Health week promotion in the month of May to promote preventive screenings.
- Partnering with promising fitness centers such as Slimmer Stronger You to promote behavioral change; polynerian diet (plant-based diet with or without lean meat); weight management; cholesterol, glucose and blood pressure monitoring.
- Maternal and postpartum depression can be done at Women's Health, Well Child and Primary Care Clinics.

Perinatal/Infant Health

a. Summary of strengths
Preterm births have gradually decreased in the past 6 years, from 9.14 per 1000 livebirths in 2014 to 5.92 per 1000 livebirths in 2019. Number of pregnant women have also been decreasing in the past five years. Approximately 80% of babies are born with normal weight and only 4% are born with low birth weight. Federal assistance has made it possible for pregnant women and infants to thrive, including nutritional assistance from WIC, free prenatal and well-baby check-ups. These strengths are mainly due to current collaborative efforts between DOH, LBJ Hospital, WIC and Medicaid to promote favorable birth outcomes and thriving babies in American Samoa.

b. Health Needs
Health Priority 3: Families are empowered to make educated choices about infant health and well-being.

Having families make appropriate healthy choices are critical to favorable birth outcomes and healthy babies. Empowering mothers to make informed decisions not only with improving health literacy but also promoting a healthy supportive environment is also important. Promoting proper nutrition, both during pregnancy and after pregnancy for both mom and baby are equally important. Providing and promoting educational resources for women and families to make informed decisions in taking care of their health and wellbeing are crucial.

Health Priority 4: Establish a Newborn Metabolic Screening Program in American Samoa

American Samoa is the only US Territory without a newborn metabolic screening. Babies born with congenital and metabolic disorders are not obvious most of the time until they are tested at birth and treated early. In American Samoa, routine newborn screening is not done at birth unless there is an obvious indication to do so. During stakeholders' meeting, there was an unanimous consensus that it was time to focus our collaborative efforts in mandating and implementing a Newborn Metabolic Screening in American Samoa. Despite the odds in the past with lack of funding, manpower laboratory equipment, by forming a NMS Taskforce with is endorsed at the territorial level with legislature back-up, it can become a reality.

c. Challenges and gaps

During focus groups and key-informant interviews, some of the challenges and gaps identified were:
1. Support Infant Health and Wellbeing:
- Baby-Friendly Initiative in the hospital is not enforced especially with allowing mommies to give formula to their babies.
- Breastfeeding Coalition do not regularly meet to discuss annual goals and objectives
- Not all work places promote favorable working environment to support breastfeeding
- There is no legislation to mandate paid maternity leave for all working postpartum mothers

2. Newborn Metabolic Screening:
- No law to regulate the hospital to provide newborn metabolic screening
- No funding locally earmarked for metabolic screening
- No federal funding available for newborn screening
- Local laboratories are not equipped. Nearby Hawaii do not test their own blood samples, but mail their samples to a laboratory in Oregon. It will definitely be a challenge to identify a laboratory who is willing to test our samples outside of American Samoa.
- Environmental

4. Current efforts to address health needs

- Promote Infant Health and Wellbeing
  - MCH Health Educators providing BF tips, reminders and support at Prenatal clinics and Maternity Ward
  - Labor and Delivery nurses and providers support placing infants on mommy's chest to initiate BF within one hour of life
  - WIC peer counselors continue to provide counseling and assistance through the BF Warmline
  - Breast pumps and other aiding tools are distributed at WIC offices
  - WIC nutritional assistance package for postpartum moms are more than those for non-breastfeeding moms.
  - Public service announcements on the radio and local tv talk-shows throughout and during breastfeeding week in the month of August.
  - Women's and Pediatric clinics Promote the BF Executive Order Policy for all government agencies by issuing BF certificates for moms to take the two hours off during working days up to 6 months to promote breastfeed.
  - Hospital Labor and Delivery staff policy include initiate breastfeeding within one hour of birth unless unable to do so
  - Hospital promote mommies rooming with babies

- Newborn Metabolic Screening
  All MCH partners including Pediatricians and Laboratory mangers agree that this will be the new focus for the next five years, **establishing Newborn Metabolic Screening in American Samoa.**

5. Opportunities for improvement

- Promote Infant Health and Wellbeing
  - Revise Baby-Friendly Initiative policies in the hospital and enforce no Baby Formula unless medically indicated
  - Breastfeeding Coalition regularly meet to discuss annual goals and objectives
  - Promote favorable working environment in the workplaces to support breastfeeding
  - Legislate paid maternity leave for all working postpartum mothers
  - Finesse all mass media campaign to promote uniformity, literacy and culture sensitivity.

- For the next five years, MCH Title V will initiate a Newborn Screening Taskforce to:
  - Generate a strategic plan for implementing Newborn Screening
  - Introduce to legislature a bill and budget for approval
  - Engage buy-in of a qualified laboratory locally or off-island
  - Train providers, local laboratory staff, care coordinators, Medicaid and billing staff
  - Promote community awareness
  - Advocate and enforce Implementation of newborn screening at birth
  - Ensure policies in place also include referral for treatment in a timely manner once diagnosis is made.

Child Health

a. Summary of Strengths

High immunization coverage of routine vaccinations like the measles, mumps and rubella (MMR) is a strength for the child health MCH population domain in American Samoa. This was evident during the recent measles outbreak in American Samoa from November 2019 to March 2020. The 1st MMR dose for school age children (both public and private schools) and children in childcare services at 12 months and older, was estimated to be at 99.5%. In addition, 2nd MMR dose coverage for the same group was estimated to be at 99.5%. For the measles outbreak situation in American Samoa, a total of 16 laboratory confirmed measles cases and 0 deaths were recorded. However, the measles outbreak situation in neighboring Samoa was unfortunate. A total of 5,707 measles cases and 83 deaths (~80% among children less than age 5 years) was documented. WHO and UNICEF estimated MMR coverage in Samoa among young children to dramatically decrease from 74% in 2017 to 34% in 2018. The low MMR vaccination coverage in 2018 is largely attributed to the deaths of 2 infants who were mistakenly injected with the wrong MMR vaccine mixture.

b. Health Priority Needs

Developmental Screening
Ages and stages questionnaire (ASQ) is a developmental screening tool that will be utilized for the child MCH population domain. Specifically, ASQs for the following child ages: 14 months, 16 months, 18 months, 20 months, 22 months, 24 months, 27 months, 30 months, 33 months, 36 months, 42 months, 48 months and 54 months will be utilized. Most of the above ASQs for child health are conducted around the time a child is due for a vaccine. ASQs are easy to use and have a parent centered approach. Studies have shown consistently that when development of a child is assessed is early on, there is an increase chance of the child to reach his or her full potential.

Oral Health
Data from the 2019 ASDOH Basic Oral Screening for school children (Grade 1-3) in public schools, strongly suggest oral health to be a priority for the child MCH population domain. When compared to US National data, American Samoa school children had a much higher number of decay and a significantly lower number of dental sealants. About 80% of AS school children had a decay experience compared to about 50% of US school children. For untreated decay, about 75% of AS school children had evidence of it compared to about 15% of US school children. The high occurrence of decay, mostly untreated may be due to the low number of AS school children with dental sealants at about 5% compared to about 40% in US school children.

Obesity
The high prevalence of obesity in American Samoa has been well documented. The recent population based, Adult Hybrid Survey (2018) has noted a significantly high prevalence of obesity (BMI of 30 or higher) of about 80% among adults in American Samoa. Furthermore, BMI data from the local WIC program have strongly suggest a continued increase of obesity in children (2 to 4 years) of American Samoa (~17% in 2014 to ~19% in 2016).

c. Challenges and gaps

Developmental Screening
The wide implementation of developmental screening tools like the ASQ-3 questionnaires to children of the MCH child health population domain (>1 year to 9 years) is fairly new in American Samoa. Early Intervention Programs like Part C is one of the few programs locally who are able to perform ASQ tools consistently and at appropriate ages. However, the Part C Early Intervention Program is limited to perform appropriate ASQs on children up to age 3 years and are eligible for their program, children with a developmental delay.

Oral Health
The MCH Title V Program does not have a full-time dentist. A full-time dentist of the Community Health Center currently leads the one team to conduct Basic Oral Screening for schoolchildren. In addition, there have been several competing public health campaigns like elimination of neglected tropical diseases like the lymphatic filariasis and immunization campaigns like the MCV, HPV, Tdap and MMR vaccines.

Obesity
Nutrient deficient processed foods and drinks are easily accessed by children. Processed foods and drinks are cheap and are also conveniently accessed by children and their families. Most grocery stores locally have a much larger inventory of processed foods and drinks compared to nutrient dense whole foods.

d. Current efforts to address health needs

Developmental Screening
ASQ-3 questionnaires were first introduced to MCH Zika Client Navigators in mid-2019. Therefore, most children part of the MCH Zika Program have passed the age to conduct most of the ASQ-3 questionnaires. In addition, some Community Health Center providers for children have begun to use the ASQ-3 developmental screening tools in early 2020. However,

the use of ASQ-3 questionnaires by both MCH Zika Client Navigators and CHC children providers has been inconsistent.

Oral Health
There is only one dental team which consists of a dentist and dental assistant performing Basic Screening Survey in school children. Due to the limited staff, BSS is limited to school children grade 1 to 3 in public schools.

Obesity
There are very few programs in American Samoa who are addressing the obesity problem in the territory. School sports are not available to school children until they reach the age of 10 years. Private leagues for sports like baseball and soccer are only available at least once a year. A set physical education (PE) and proper nutrition curriculum is not part of the public-school system in American Samoa.

e. Opportunities for improvement

Developmental Screening
Early developmental screening is important to the growth of a child. It is pertinent that we are able to identify a developmental delay of a child early on so the appropriate interventions are implemented in a timely manner. Therefore, developmental screening at appropriate ages based on the ASQ-3 screening tool should be mandate by law in American Samoa. High immunization coverage for routine vaccines like MMR is a result of the immunization mandate before a child is enrolled in school both public and private schools.

Oral Health
In addition, to developmental screening and immunization, oral health screening should also be a requirement before school enrollment. Oral health is a strong indicator of a child's overall health. Tooth decay shows a diet high in sugar sweetened foods and beverages, and would suggest the increase likelihood of childhood obesity.

Obesity
A standardized and locally relevant PE and nutrition curriculum should be implemented from kindergarten to grade 4. Early intervention for obesity at childhood has been shown in studies to be successful. Standardized PE and nutrition curriculum should follow guidelines from the American Academy of Pediatrics and Center for Disease Control and Prevention.

Adolescent Health

a. Summary of Strengths
For adolescent health, there have been past and existing infrastructures. The Pacific Island Center for Education Development (PICED) was one of the first programs to address adolescent health specifically through education in the early 2000s. PICED services included college bound courses like standardized testing preparation and college applications. PICED has paved the way for existing adolescent infrastructures like Intersections Inc. However, Intersections Inc. offer a range of services from college preparation courses to addressing behavioral health of adolescents.

b. Health Priority Needs

Weight management: Obesity
As mentioned previously, obesity is a well-documented problem in American Samoa. According to the Youth Risk Behavior Surveillance System (YRBSS) survey, obesity among adolescent age 14 to 17 years has increased significantly from 35% in 2007 to 45% in 2015. In addition, MCH stakeholders including providers and educators have affirmed this significant change in the weight of adolescents in American Samoa.

Reproductive Health
The American Samoa teen birth rate has decreased from 45 births per 1000 population in 2013 to 31 births per 1000 population in 2019. However, US Pacific Island territory like CNMI have a low birth rate of 15 births per 1000 population.

The US national average teen birth rate is also much lower at 24 births per 1000 population.

Behavioral Health
Bullying and suicide have been shown to be significant behavioral health among adolescents in American Samoa according to the YRBBS data. Adolescents reported bullying on school property has increased from 25% in 2011 to 30% in 2015. Furthermore, there is an increasing number of adolescents who reported to have attempted suicide from 20% in 2007 to 25% in 2015.

c. Challenges and gaps

Weight management: Obesity
Like child health, a standardized and locally relevant PE and Nutrition curriculum is not in place. Therefore, addressing weight management has not been fully addressed.

Reproductive Health
Sex or reproductive health education is a taboo subject in communities like American Samoa. There is a common misconception in the community that reproductive health education promotes sexual behaviors among adolescents. Furthermore, American Samoa is a community with significant Christianity influence.

Behavioral Health
Mental health is undermined in American Samoa. Emotions and feelings are encouraged to be limited to the individual. Adolescents are not seen at the Well Child Clinic by the Pediatrician for an annual check-up but get their check-up at the Primary Care Clinic which also caters to all age-groups. It is recommended for all age-groups to have a depression/behavioral screening and immediately gets counseling at Tafuna CHC. Unfortunately, not all clients get a mandatory depression screening.

d. Current efforts to address health needs

Weight management: Obesity
A range of sports like volleyball, soccer, and football are offered from middle school to high school (Grade 5-12). However, spots to play each sport are limited and therefore, not all adolescents are able to participate in sports activities.

Reproductive Health
Reproductive health education through Family Planning is only limited to adults and married couple. Young and single individuals like adolescents are discouraged to explore family planning options.

Behavioral Health
Current programs for adolescents like Intersections Inc, Boys and Girls Club and Teen Challenge are addressing behavioral health.

e. Opportunities for improvement

Weight management: Obesity
The standardized and locally relevant PE and Nutrition curriculum should be implemented from child health years up to adolescent years. This implementation must involve the adolescent, family and their communities either church or village. When all parties work together, implementation of the standardized and locally relevant PE and Nutrition curriculum.
Reproductive Health

With existing infrastructures of adolescent health, safe and open conversations about sex education can occur. The approach is to not promote sex but raising awareness so that adolescents can have more informed decisions.

Behavioral Health

Through the same infrastructures for adolescent health, a safe haven and open space to address mental health. Furthermore, trained individuals to maintain the confidentiality in small communities like American Samoa.

Children with Special Health Care Needs

a. Summary of Strengths

- CSHCN Client Navigator worked alongside with the Zika Client Navigators to share information, ideas and resources to improve services.
- CSHCN Client Navigator schedules appointments and coordinates primary care and dental visits for CSHCN clients at the district health centers.
- Transportation is available to assist clients who may need a ride to and from the clinic.
- The CSHCN Program is benefiting from screening opportunities through the Zika Program. These screenings are for vision and hearing. These screenings are accessible at no cost to the families with free transportation to access these clinics during weekends or after hours.
- The CSHCN continues to partner with the Parents Network of children with Special Needs during the summer months to support a one-week summer camp catered for the specific population.
- CSHCN continues to work closely with Medicaid and the LBJ Hospital to determine what can be sponsored by funding that is available towards durable medical equipment that is much needed by many of the children with special needs, but are too expensive to be purchased by individual families. CSHCN Navigator is the key in this process, to assure that specific health needs are met and supported, and resources are identified with payment guaranteed.
- Client Navigators work closely with Helping Hands Early Intervention Program to refer children for EI if child is eligible, and vice versa.

b. Health Priority Needs

- Very low rate of Early Diagnosis and Treatment/Management
- Lack of mandatory Newborn Metabolic Screening in American Samoa
- Lack of specialists in American Samoa

c. Challenges and gaps

- Limited resources and specialty care for CSHCN (PT, OT, Speech Therapy, Neurology, etc.)
- There is no current count of CSHCN island wide, so it is still a challenge to develop plans that can service and support this group. The count for children in the school system with an Individualized Education Plan (IEP) includes children who are identified to have a learning disability and not necessarily a developmental disability. Therefore, this number could be an overestimate of the CSHCN population.
- Limited advocacy from families of CSHCN due to lack of understanding pertaining to rights and service that are beneficial to this population.
- Providers may not be comfortable with serving the CSHCN population due to lack of training on specialty care.
- Interagency on disabilities need to be restored and strengthened, to be advocate for people with disabilities, including children.

d. Current efforts to address health needs

- Due to the Measles Outbreak and COVID-19, the client navigator can only manage to provide care coordination by conducting daily phone calls to follow up on the client and schedule appointments when needed by the clients.
- The CSHCN Program is collaborating with the newly established Family to Family Health Information Center to increase parent and family participation with the center and to determine advocacy activities that would best fit the needs of families and their CSHCN.
- Currently working with the Leo o Aiga, Family to Family Center to recruit clients to the Dial a Ride program to assist with transportation to and from clinic, WIC, Food Stamp and so forth.

e. Opportunities for improvement

- Transition Zika Navigators to work as Care Coordinators for CSHCN to help manage cases and provide care coordination to this population
- Incorporate health care plan (HCP) for family-provider (parent/guardian, primary provider, care coordinator, nurse practitioner)
- Create Standard Operating Procedures (SOPs) on how to implement HCPs and engage families/parents to promote Family/Patient centered care models and preparation for adult transition.
- Offer training for providers on Family/Patient Centered Care.
- Engage LBJ Pediatricians and other specialists with WBC providers in collaborative coordination for CSHCN. Also, a

clarification will be needed to improve communications and referral protocols for CSHCN Care Coordinators (Client Navigators) and providers.
- Telehealth options

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

The American Samoa Maternal and Child Health (ASMCH) Program under the Department of Health supports existing health care services in American Samoa that caters to improving the health and wellbeing of women and children, including children and youth with special health care needs. The MCH Title V is currently under the leadership of the Nursing Director, who reports directly to the Director of Public Health as shown in Figure 1. Director of Public Health (ASDOH), Director of Human and Social Services (runs WIC and SNAP) and the Chief Executive Officer of the LBJ Tropical Medical Center Authority all report directly to the Governor of American Samoa.

The MCH Program Director, Mrs. Margaret Sesepasara also oversee other programs within ASDOH (Figure 3). This includes MIECHV, Immunization Program, and Nursing Home Visit. Other related programs include Helping Babies Hear (EDHI) and Helping Hands (EI). All these programs meet regularly to discuss referred patients from LBJ and other agencies, streamline goals and objectives to prevent duplication of services and plan annual activities together in collaborative projects. Most Title V direct and enabling services are carried out within the Community Health Centers (Figure 2). MCH Staff consists of a Nurse Practitioner, Registered Nurse, CNA/Health Educators, Dental Assistant, Client Navigators, and Administrators. MCH Title V collaborates with ASCHC to identify gaps in available services and assist in filling those gaps. Majority of these gaps are enabling services such as health education and care coordination. In return, program staff is promoting MCH health priorities and services identified annually through regular Needs Assessments and DOH priorities as a whole.

Low risk pregnant women are encouraged to utilize the nearest prenatal clinic within their districts. Low risk pregnancies are women who have no existing chronic condition, Gestational Diabetes, previous cesarean births and other complication in previous pregnancies. Those who live in the central villages (closest to the Hospital), together with all high-risk pregnant women, receive prenatal care at the LBJ Hospital. At 37 weeks, all pregnant women who were served at CHCs are also transferred to the Hospital. MCH provides health education during these visits, appointment reminders and care coordination. All women's postpartum information is collected and linked to their newborns and their birth information. Pediatrics Department at LBJ Hospital refer all premature babies and newborns with birth defects and syndromes to MCH for care coordination, and continued monitoring.

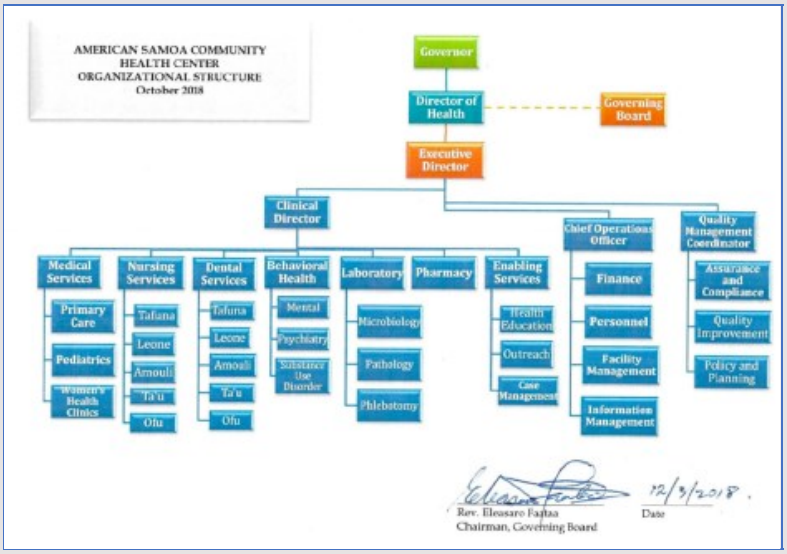
MCH Title V pick up newborn cards from nursery and deliver them to each community health center where each will receive wellness visits and routine immunization. This is also where children should be receiving developmental screening and referral to EI. All preventive, primary care services are provided for the MCH population at the Community Health Center unless they need acute care, then they are referred to LBJ Hospital. All US citizens, permanent residents and foreign pregnant women and children are covered under Medicaid and hence CHC and LBJ Hospital will receive Medicaid reimbursement. All other population who are not US citizens or US Nationals (born in American Samoa) will not be reimbursed by Medicaid. All DOH services are free for all women and children at the Community Health Centers.

Family Planning is currently being addressed at LBJ Hospital who is the grantee for Title X, and the Tafuna CHC Women's Clinic who is funded by the CMS-Zika Supplemental grant. All women are referred to either clinic depending on preference and convenience. Types of contraceptives also determine where to refer women to. LBJ Hospital has a variety of resources and Tafuna only supplies pill contraceptives and condoms.

MCH Title V administer and coordinates all funded activities earmarked to accomplish annual State Action Plan. All activities are preapproved by the Program Director and then the Director of Health. MCH Title V also supports public health essential services including monitoring and tracking of all MCH health status across all programs within ASDOH, provides health trends, morbidty and mortality rates. MCH Title V Epidemiologist and SSDI funded Epi Tech are responsible for such Public Health Surveillance. They both work closely with the Territorial Epidemiologist to ensure weekly, monthly and annual reports

are send out across ASDOH programs and ASG agencies and any other community organizations that may request for MCH Health Indicators or Measures. Refer to the supporting documents for the various Organizational Charts.

Figure 2: American Samoa Community Health Center Organizational Chart



III.C.2.b.ii.b. Agency Capacity

The Public Health Services Systems Model for MCH Populations defines the core functions of Public Health as Assessment, Policy Development and Assurance.

Direct Services: The Essential Services of Public Health Standard is to Provide Access for Care. Direct services are preventative, primary or specialty clinical services to MCH populations. Mrs. Tele Hill(NP) and Dr. Mirella Chipongian are the two Providers for pregnant women, Dr. Faiese Talafu provides the care for children including children with special health care needs, Dr. Raymond Almeda serves children with RHD and Dentist Inoke Siasau provides dental care for children at all ages. The services are not limited to preventive, primary or specialty care visits, urgent care visits, outpatient care for mental and behavioral health services, and prescription drugs. All direct services are offered through the Tafuna Family Health Centers and its satellite clinics across the island.

Enabling Services: Enabling services are non-clinical services (not included as direct or public services) that enable individuals to access health care and improve health outcomes. The funding provided by MCH Block Grant is used to finance these services for MCH populations. The Essential services of Public Health Standard is to investigate health problems, inform and educate the public and engage community partners. In addition, promoting and implementing evidence based practices with access and monitoring MCH Health Status are also enabling services. The MCH Program funds for an epidemiologist who helps to interpret data to guide decisions to improve health for women and children. Also, MCH affords for health educators to provide education on nutrition and healthcare for women who come to the clinic, as well as case managers and navigators who help guide families and consumers in accessing pertinent care for their health needs. These MCH staff engage in community capacity building to deliver enabling services, such as transportation, nutrition counseling, and care coordination.

Public Health Services and Systems: Public Health Services and systems are to support and maintain Public Health Workforce and develop public policies and plans for the benefit of the society. Enforcing Public Health laws and ensuring quality improvement are essential services for the Public Health standard. These services include the Epinet and surveillance to monitor changes in the health status of the population, as well as providing necessary training for the work force and staff. Another MCH initiative to support public health services is the success in pushing for an executive order to allot two hours of breastfeeding time for all working mothers in the government. This order was signed by the Governor and

is currently being implemented in American Samoa.

III.C.2.b.ii.c. MCH Workforce Capacity

MCH Title V Bureau at the National level provides ongoing Technical Assistance in collaboration with AMCHP, Public Health Schools and other federal entities to improve and promote MCH Workforce Capacity at the state and territorial level. American Samoa is very much grateful to Dr. Warren and his excellent staff, especially Mrs. Michelle Lawler, for the programmatic support and enabling the USAPIs to have its own Spring TA in Hawaii for the past five years. Having the opportunity to get trained, network and share best practices among Pacific Island Jurisdictions with similar cultures, geographical locations, population sizes, enabled a friendly, familiar environment conducive to learning definitely improved confidence, programmatic competencies and workforce capacity.

In the past five years, ASMCH Title V has improved in building and implementing some of the core public health functions including assessment, policy development and assurance. American Samoa Title V has improved in terms of increased accountability through ongoing performance measurement and monitoring required to have an adequately sized and skilled workforce.

Example of programmatic skills, resources and tools learned and applied are listed below:

- Systems mapping
- Work flow charting
- Formulating Policies and implementation
- Fostering Partnerships and Collaboration skills
- Implementing Focus groups
- Improved epidemiological skills, data collection and surveillance
- Finance, expenditures tracking and reporting
- SMART objectives and MCH Evidence (ESMs)
- Annual reporting and applications
- MCH leadership skills and competencies
- Return on Investments
- Public Health essential services
- Needs Assessment Framework and Implementation

(i) Number, location and full-time equivalents of state and local staff who work on behalf of the state Title V programs

ASMCH Title V had only 8 full time funded staff 8 years ago. Fast forward, we are expecting 17 staff to be fully paid or in-kind to run Title V efficiently.

Staff Position Description	Quantity	Location	FTE
Title V Program Director *Margaret Sesepasara, NP*	1	Nursing Office MIECHV MCH Clinics	.50 0.25 0.25
Title V Program Coordinator *Dr. Anaise Uso*	1	Title V Office	1.00
CYSHCN/RHD Program Coordinator *Ipuniuesea Eliapo-Unutoa*	1	Title V Office	0.75
CSHCN/RHD Case Manager *Emmalaine*	1	Title V Office	1.0
CSHCN/Zika Client Navigator *Fetina'i Taitai*	1	Title V Office	1.0
RHD Client Navigator *Lotu Tupuola*	1	Tafuna CHC Title V Office	.75 .25
MCH Epidemiology Tech. *Ruta Ropeti*	1	Title V Office	1.0
MCH Epidemiology *Mata'uitafa Faiai*	1	Title V Office	1.0
Nurse Practitioner *Tele Frost Hill*	1	CYSHCN/Fagaalu Well Child Clinic Prenatal Clinic	0.75 0.25
Registered Nurse *Sweetheart Nua*	1	Leone Well Child Clinic/CSHCN	1.00
Health Educator/Certified Nurse Aids *Conference Alailefaleula* *Manulelei Silva-Aitaoto*	2	CHC Women's Clinic LBJ Hospital OBGYN Fagaalu Primary Care Clinic	1.00 .05 .05
Certified Dental Assistant/Administrator *Matauaina Ifopo*	1	Dental Clinic Well Child Clinic	.05 .05
Certified Nurse Aid *Faafetai Meleisea*	1	Leone Well Child Clinic	1.0
Zika Client Navigator/CSHCN Driver *Sa Savaii*	1	MCH Title V Office	1.0
Cardio-Pulmonary Tech *Hiring in Progress*	1	CHC and Schools	1.0
Finance Officer (Local funded salary) Paul Peko	1	DOH Main Office	0.10

(ii) Names and qualifications of senior level management employees who serve in lead MCH-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities

Staff Position Description	Types of State Level Management Roles
Title V Program Director *Margaret Sesepasara, NP*	Departmental planning and evaluation for all programs and policies at ASDOH. Oversee all training and quality improvement projects for nurses. Mrs. Sesepasara is a Nurse Practitioner by profession and has been serving women and children for more than twenty years.
Title V Program Coordinator *Dr. Anaise Uso*	Departmental planning for all MCH related activities within ASDOH. Departmental planning and media relations for all public health emergencies and outbreaks in American Samoa. Dr. Uso is a general dental practitioner and has been working in the administration capacity for the past six years.
CYSHCN/RHD Program Coordinator *Ipuniuesea Eliapo-Unutoa*	Departmental planning for all MCH related policies and activities within ASDOH. Departmental planning and media relations for all public health emergencies and outbreaks in American Samoa. Mrs. Eliapo-Unutoa has a Masters in Occupational Therapy from Loma Linda University. She has been working for ASDOH for the last 19 years under Title V and CSHCN.
MCH Epidemiologist	Planning, Monitoring and Reporting of all Public Health Epidemiological Surveillance in American Samoa

(iii) Number of parent and family members, including CSHCN and their families, who are on the state's Title V program staff.

Family Members	Title V Role
F2F Office Administrative Assistant *Mocha Mua*	Paid by F2F Leo o Aiga. Not only does she work as an administrative assistant but she is also instrumental in recruiting CSHCN families, point of contact for families during Needs Assessment and provides resources for families when they call Title V office. Mrs. Mua is also a parent of a child with special health care needs. She has an AA degree from the American Samoa Community College.
CYSHCN/RHD Program Coordinator *Ipuniuesea Eliapo-Unutoa*	Mrs. Eliapo-Unutoa is a parent of a child with special health care needs. She is extremely passionate about the work that she administers not only because of her educational background but she is also advocating for her loved ones.

(iv) Additional MCH workforce information, such as the tenure of the state MCH workforce and projected shifts in the MCH and CSHCN workforce over the five-year reporting period, that aligns workforce capacity with the achievement of Title V program goals.

ASMCH Title V has come a long way not only in increasing staffing, funding but also service capacity. Shifting the needle from direct care to more public health and enabling services are not easy especially for a low-resource island territory such as American Samoa. ASDOH still depends on MCH Title V to assist with the Nursing department and its initiatives. Direct services are not just for CYSHCN but also includes women and children as long as Title V is being administered by the Nursing Department. Title V administration will continue to promote its priority needs and state action plan in order for ASDOH to understand why its federal dollars are being maximized in such a way.

As we await the new Governor and his new administration to be elected come October 2020, ASMCH Title will continue to promote and implement its new state action plan to achieve its goals and objectives for the next five years. Title V Program

will continue to collaborate with key stakeholders, utilizing current legislation and policies, to promote MCH health priorities. Program staff will continue to request for Technical Assistance annually to improve workforce development and competencies.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Title V Program Partnerships, Collaborations and Coordination
The American Samoa Maternal & Child Health Program works closely with many organizations around the country and here at home

Partners on the federal level and off-island private teams include Health Resources and Services Administration (HRSA), Centers for Disease Control (CDC), World Health Organization (WHO), Secretariat of the Pacific Communityl (SPC), US based academic institutions, and cardiology teams from off-island hospitals.

Local partners include the American Samoa Government, specifically Department of Human and Social Services (DHSS), Women, Infant, and Children (WIC) Breastfeeding Program, Department of Education Special Education Division (SPED)/Secondary Division/Early Childhood Education (DOE), Department of Office of Protection and Advocacy (OPAD), Department of Public Works (DPW) Dial A Ride Division, Department of Vocational Rehabilitation (VR), and Medicaid.

Department of Health internal programs such as Home visiting, Helping Hands Part C, Helping Babies Hear, HIV/TB/STD, Breast and Cervical Cancer Prevention (BCCP), Immunization Program, and Community Health Centers (CHC). Additionally, other non governmental entities include LBJ Tropical Medical Center (Family Planning, Maternity Clinic, Nursery, OBGYN, Pediatrics), University Centers for Excellence in Developmental Disabilities (UCEDD) under the local Community College, and the Telecommunication Companies such as American Samoa Telecommunications Authority (ASTCA) and BlueSky Communications.

Local Health Based Businesses: South Pacific Watersports (SPW), Slimmer Stronger You (SSY) focus on nutrition and physical activity.

Non-profit organizations: American Samoa Alliance against Domestic and Sexual Violence, Parents of Children with Special Healthcare Needs Network (PCSN), Intersections Inc. on teenage pregnancy prevention and teen counseling.

Church groups: (Pastors, Youth groups, etc.).

Media outlets: South Seas Broadcasting, KSBS 92.1, KVZK TV (local TV) and private media businesses.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

The methodologies utilized to help us identified the final list of priorities for each of the population domains under MCH services was detailed by the Title V Grant Guidance. We were able to produce a list of priorities that can drive the next five-year cycle in MCH work by combining qualitative information with quantitative data available from reliable sources. These priorities were presented to MCH stakeholders under specific population domains, so to gather their feedback, recommendations, support, as well as their endorsement as our partners in serving women, pregnant women, and all children including children with special needs for the next five years.

Priorities that were identified in the list but were not ranked as one of the top three from each of the population domain, were categorized as emerging needs. Emerging means priorities that are becoming apparent or prominent in the population but are not necessarily top priorities based on the data collected. There emerging priorities are still important and must be considered as it may be influential in the wellbeing of our women and children. The following emerging issues were identified under each specific domain.

Women/Maternal Health-

- Domestic Violence
- Positive marriage counseling /healthy relationships
- Reproductive Health Education in schools (13-14 years old)
- Transportation Needs for Pregnant women to access care

Perinatal/Infant Health-

- Postpartum Depression
- Immunizations.

Child Health

- Developmental Screenings for children
- Parent/Child Activities including family physical activities and their involvement with their children
- The availability of Telehealth for any public health emergencies that may occur at any time in the territory.

Adolescent Health

- Substance abuse amongst adolescents
- Child abuse
- Preventive care through recommended immunizations and annual physical assessments.

Children with Special Needs

- Resource center (support groups for families)
- Medical home (Health Follow up)
- Transportation services
- Special equipment

PRIORITIZATION:

DOMAINS	*Women and Maternal Health*	*Perinatal/Infant Health*	*Child Health*	*Adolescent Health*	*CSHCN*
PRIORITY 1	**PROVIDER COMPETENCY/PROVIDER SHORTAGE**	**BREASTFEEDING**	**IMMUNIZATION**	**WEIGHT MANAGEMENT**	**CERTIFIED PROFESSIONALS (PROVIDERS & EDUCATORS)**
PRIORITY 2	**PRENATAL CARE (Accessible/Affordable)**	**HEALTH & NUTRITION (Both Mother & Baby)**	**OBESITY**	**RHEUMATIC HEART DISEASE AND RHEUMATIC FEVER**	**TRANSITIONING PROCESS**
PRIORITY 3	**WOMEN'S HEALTH (NCDs/STDs Screening & Pre-Pregnancy**	**SCREENING (Developmental, Metabolic and Oral)**	**ORAL HEALTH**	**SUICIDE & BULLYING**	**EARLY SCREENING & DIAGNOSIS OF CSHCN**

Emerging Needs

DOMAINS	*Perinatal/Infant Health*	*Child Health*	*Adolescent Health*	*CSHCN*	*Women and Maternal Health*
EMERGING NEEDS	**Immunization**	**- Developmental Screening, Parent/Child Activities, Public Health Emergencies (Telehealth as alternative)**	**- Substance Abuse (Smoking & Alcohol); Child Abuse (Physical), Preventive Care (Immunization)**	**- Resource Center (Support Groups for families); Medical Home (Health Follow Up), Transportaion Services; Special Equipments**	**- Domestic Violence/Positive Marriage Counseling/ Health Relationships; Sex education in schools; Transprotations, Postpartum Depression**

The following are some contributing factors to the change in priorities from the last reporting cycle, which were identified during stakeholder meetings.

- Growth of MCH Staff: In the past 5 years, MCH only employed a staff of 7 which includes 1 Program Director, 2 Program Coordinators, 2 clinical staff and 2 health educators. This past year it has increased to a total staff of 21 under different programs within MCH.
- Drop and rise in the economy: Due to natural disasters, outbreaks, and the most current COVID situation, the change in economy directly effects MCH priorities. In the past, outbreaks such as Zika prioritized accessibility of care for pregnant women, then with the measles outbreak, more emphasis was placed on immunizations for all children population as well as adults. With the influx of federal assistance after natural disasters, families were more able to afford necessary nutritional food items than before.
- New federal funding: New financial opportunities from the Federal Government enabled programs such as the "Leo o Aiga Health Information Center" to be in existent to assist families of children with disabilities within the community.

In conclusion, MCH was tasked to take the selected priorities from each of the population domains and strategically look at evidence-based programs or approaches that will best fit the needs of our women and children. From there, strategies that are culturally appropriate, evidence-based, accessible, family centered, coordinated and comprehensive would be selected to achieve specific objectives assigned under each population domain priority. These will be included in the next five-year MCH plan to guide the work that our local MCH workforce will be implementing together its partners and the DOH as a whole. There will be internal and external evaluation methods conducted throughout this process annually to communicate the level of progress made and if such progress is affecting improvement in services and overall quality of life for all women and children in AS.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$485,820	$490,711	$485,500	$469,362
State Funds	$0	$368,100	$0	$0
Local Funds	$400,000	$0	$364,125	$364,125
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$885,820	$858,811	$849,625	$833,487
Other Federal Funds	$595,374	$211,805	$728,481	$827,769
Total	$1,481,194	$1,070,616	$1,578,106	$1,661,256

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$485,500	$490,243	$493,000	
State Funds	$364,125	$390,000	$369,750	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$849,625	$880,243	$862,750	
Other Federal Funds	$400,000	$333,584	$50,000	
Total	$1,249,625	$1,213,827	$912,750	

	2022	
	Budgeted	Expended
Federal Allocation	$494,000	
State Funds	$390,000	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$884,000	
Other Federal Funds	$41,017	
Total	$925,017	

III.D.1. Expenditures

FY20 Report- Expenditures

The Title V MCH block grant, together with local funds (state match) and other additional federal funds, is used to address American Samoa's MCH priority needs, improve performance related to targeted MCH outcomes, and expand systems of care for CSHCN populations and MCH. American Samoa MCH Title V expended $490,243.00 of its $492,447.00 federal allocation for grant fiscal year (GFY) 2020. This amount did not include administrative costs. The remaining $2,204.00 will be spent before the end of the award term on September 30, 2021.

In the budget allocation for FY2020, the Title V federal allocation included one third of funds to support Children with Special Health Care Needs (CSHCN) and an additional one-third to support the MCH priorities for preventive and primary care initiatives for children ages 1 to 21 years of age. FY2020 budget was initially aligned according to state action plan initiatives. These initiatives included direct services for CSHCN; enabling services for all population domain; and supporting public health services and systems to improve overall health for all women and children.

However, some of the objectives and initiatives in the FY2020 State plan were not accomplished due to the Measles Outbreak (September 2019 – March 2020) and COVID-19 emergency operations (Governor's March 2020 Declaration). Majority of the Title V staff including the program manager were called to man the Unified Health Command Center and oversee Risk Communications. One major unplanned initiative Title V funds were utilized for was providing overtime for Title V staff to operate the Command Center during the Measles outbreak beginning, September 2019, which transitioned into COVID-19 operations and later assist the **Suicide Prevention Call Center** as operators. This correlated with the increase suicide rates among young adults reported in 2020**.** Mr. Motusa Tuileama Nua, Director of Health and the Director of Human and Social Services agreed to house this call center at the DOH Behavioral Health Services Division. It started as a 220 number back in August 24, 2020 and then it was converted to 988 by April 4, 2021. Majority of the funds in the Travel Category was utilized for this initiative.

This narrative correlates with the budget forms 2 and 3 in this application and FY 2020 annual report. According to American Samoa's Title V expenditure report in Form 2, 30.9% of funds were used for children with special health care needs, up to 21 years of age, and 46.5% of funds were utilized to fund preventive and primary care initiatives for children ages 1 to 19 years. This 16.5% increase for children services was definitely unplanned. Majority of this percent focused around mitigating the Measles outbreak (by boosting risk communications, MMR vaccinations, community and school outreach, border closure), manning the suicide prevention hotline and assisting with COVID-19 operations.

MCH funded staff were deployed to provide COVID-19 testing; epidemiological surveillance and monitoring; man quarantine stations; and provide transportations beginning March 2020 when borders closed due to COVID-19 cases increasing in the US. Some Title V staff working after-hours was also funded by CHC COVID-19 grants. CDC funded program Epidemiology and Laboratory Capacity could have funded the Epinet Team but accounts were not open or available locally in a timely manner.

Other Federal Funds

Other federal funds which assisted with Title V office operations, office lease, client transportation, data capacity and

staffing included the MCH-Zika Services, SSDI, MIECHV, and CDC funded Preventive Health Services grant. Aiga Manuia MIECHV cost shared salaries for MCH Epidemiologist and Finance Officer. Preventive Health Services assisted with the Heart Health Week Initiative that promoted RHD screening and Bicillin medication compliance. MCH Zika-Services grant funded Client Navigators; cost share with MEICHV the MCH Epi's salary; assist with office lease, communications, operational costs, and transportation maintenance.

State Match

The state match was obtained through various means, both cash and in-kind match. State match included 50:50 cost share funding four MCH staff including two nurse practitioners, one registered nurse and the RHD Program Coordinator. In-kind match included facility and operational costs for the central Well Baby Clinic in Fagaalu, medical supplies and local funded nurses. State match also funded administrative costs for the MCH population. DOH Finance Office continues to monitor expenditures regularly to ensure compliance with legislative financial requirements.

Other Local Funds

Community donations funded antibiotic prophylaxis for Rheumatic and Rheumatic Heart Disease patients enrolled in the Manumalo le Alofa RHD Program. This is a 340B discounted federal program which enables affordable medications and make it more accessible to this population. In early FY19, two schools donated funds to kick-start the Manumalo le Alofa by purchasing medications for RHD patients.

AS Title V Workforce

AS MCH Title V Block grant funds 12 employees. This includes the **MCH Program Manager** overseeing the daily operations at the Title V office and staff. During COVID-19 she was activated to be part of the Epinet Team and administer COVID-19 screening at airport and seaport, as well as working at the Unified Health Command Center, coordinating Risk Communication during Measles Outbreak and COVID-19 operations. Four MCH staff is cost shared with local match (State Match) which includes **2 nurse practitioner**s, one **registered nurse** and the **RHD Program Manager**. One nurse practitioner mainly provides training, administration for nurses and covers at the Women's Health or Well Baby Clinics when clinics are short with nurses. The other nurse practitioner provides prenatal care and postpartum check-up. She no longer provides direct services for CSHCN needs, most of the CSHCN are enabling services such as care coordination and transportation. CSHCN and their families are encouraged to utilize services at Tafuna CHC and LBJ Hospital and improve accessibility and utilization rates. This is the reason why direct services are low and enabling services have a high percentage for CSHCN. In 2020, Zika Client Navigators assisted with care coordination for CSHCN due to lack of staffing.

Two health educators are situated at the Women's Clinic and the Physical Clinic. One of the Health Educator recently passed her boards for Licensed Practical Nurse towards the ending of FY2020 and was instrumental in boosting MMR vaccinations in the community. An MCH funded **Certified Nurse Assistant** works at the Leone Well Baby Clinic to provide enabling services for children.

There is one **RHD Client Navigator** who schedules and provides reminder calls for RHD Clinic patients. She monitors her own RHD data in a spreadsheet. There is also an **SSDI funded Epi Tech** who assists the **MCH Epidemiologist** with MCH Surveillance which contributes to Public Health services and systems capacity.

The **MCH Certified Dental Assistance** works closely with the Tafuna Community Health Center to provide oral

health preventive services for perinatal and children population.

30/30/10 Requirement

To assure the 30/30/10 requirement is properly documented and to record expenditures by the MCH Pyramid Services, ASMCH continues to utilize specific budget project titles in the Expenditure Tracking Spreadsheet it uses. American Samoa tracks expenditures to comply with the Title V 30/30/10 legislative requirements. That is, a minimum of 30% of total funding must be expended for CSHCN; a minimum of 30% of total funding must be expended for preventive and primary care for children; and a maximum of 10% of total funding can be expended for Title V administration. This tracker was able to determine the unplanned increase in preventive services and primary care for children of 46.5%. The remaining percentages of expenditures were for pregnant women, mothers, infants and others. Funding for these populations supported health education, screening and counselling and surveillance mechanisms such as pregnancy, postpartum and newborn surveillance, ongoing needs assessment as well as emergency preparedness and response.

Payer of Last Resort

American Samoa DOH strongly supports Title V regulations to use Title V funds as the payer of last resort. The comprehensive Title V-Title XIX IAA signed back in 2018 is still in effect. Title V and Medicaid met back in 2019 to review the current MOU still in effect and have agreed to revise the current language to a more comprehensive list of services that Title XIX covers so that Title V is the payer of last resort. Due to the current pandemic, the IAA have yet to revised. The remaining Title V funds are used for systems-level work in infrastructure or related to the ten essential services which are non-claims related reimbursement.

Challenges

AS MCH Title V current workforce are crossed trained to perform various roles within the Department of Health due to workforce shortages and limited workforce capacity. Emergency Preparedness Division, Tafuna Community Health Center and ELC all have COVID-19 funding. Unfortunately, they do not have sufficient staff to administer these grants or their activities. Government hiring process and limited public health experts available in the territory is still lacking. The flexibility in the Title V grant provides an opening for COVID-19 funded programs to quickly utilize MCH staffing for public health emergency operations but slow to accommodate after-hour compensations. Transferring funds back into the program will take time because of certain restrictions within these COVID-19 funds. It would be helpful if MCHB were to assist justification to COVID-19 grantors the importance Title V workforce roles in current pandemic operations and allow state and territories to apply for such COVID-19 supplemental funding.

III.D.2. Budget

The Table below is a breakdown of the FY2022 Budget appropriations by MCH initiatives.

Early Prenatal Care & Well Women's Visits	$80,000.00
Breastfeeding Initiatives	$10,000.00
Metabolic Screening	$10,000.00
Children's Wellness Visits & Developmental Screening	$29,000.00
Oral Health	$21,000.00
RF and RHD School Screening and Treatment	$50,000.00
Immunization Coverage	$26,000.00
Adolescent Health	$24,000.00
Care Coordination and medical home for CSHCN	$148,200.00
Centralized Database and Public Health Systems	$85,800.00
Total Title V Block Grant	**494,000.00**

Through state level programs and initiatives as well as Department of Health activities, these appropriations will be used to support work related to the following National Performance Measures (NPMs):

• NPM 1 (Well-woman Visit)

• NPM 4 (Newborn Screening and Breastfeeding

• NPM 6 (Children Developmental Screening)

• NPM 10 (Adolescent Well-visit)

• NPM 11 (CSHCN Medical Home)

At the territorial level, the National Performance Measure 11 should be the only population to receive direct services under Title V allocations in FY 2022. But in American Samoa, due to shortage of clinicians MCH staff are also providing direct services to women's health, including prenatal and postpartum care. This is in part due to the most critical and immediate MCH needs, as well as the need to fill funding gaps that would otherwise exist without Title V funding. There are currently two MCH funded staff providing care coordination for CYSHCN. They are only able to serve 30 clients each. A third case manager will be hired to increase service capacity and number of clients served.

Additionally, most of the other activities like NPM 10 are largely supported through the HRSA FQHC funds to the Community Health Centers as well as the CDC Immunization Program funds (to promote HPV vaccinations) which are both administered under ASDOH. The amount above is mostly enabling and public health services related to MCH staffing providing time and effort in policies and attending advisory board meetings such as planned for Adolescent health and immunization program.

Currently, the unpredictability of COVID-19 operations and how the pandemic has involved into a more contagious Delta variant, encourages MCH Title V to be better prepared and continue to assist in a Public Health services and systems service capacity.

Title V funds will also be used at the state level and continue to directly support the work of American Samoa's SPM priority needs:

- Newborn Metabolic Screening (Perinatal Health)
- Rheumatic Heart Disease Prevention (Children & Adolescents)
- Continue to improve the Centralize MCH Database in SILAS and track MCH staff workflow and generate Title V reporting for MCH performance measures

All SPMs have robust and continuing line item allocations in the FY 2022 Title V budget, as reflected in Table 1. The state programs and activities that will support work on the above NPMs and SPMs in FY 2022 are detailed in the

state action plans.

The Others budget will go into executing public health services and systems to include continuous annual Needs Assessments and operational costs.

30/30/10 Requirement

Table 2. Title V Funds appropriated by Types of MCH Population Served.

Appropriation Name by Population Domain	FY 2022 Projected Expenditures for Title V Funds	Percentage
Preventive and Primary Care for Children	$ 150,00.00	**30.4%**
Women, maternal and infants	$ 100,000.00	20.2%
Children with Special Health Care Needs	$ 148,200.00	**30%**
Others	$ 95,800.00	19.4%
Administrative Cost	$0	**0%**
Total Costs and Percentages	**$ 494,000.00**	**100%**

American Samoa's commitment to adhere to the 30/30/10 Title V legislative requirement was discussed in the preceding Expenditures section. For FY 2022, this commitment is again reflected in Form 2 (Lines 1A, 1B, and 1C) in the Application Budgeted and in Table 2. For FY 2022, 30.4% of the total Title V budget is designated for preventive and primary care for children; 30% is designated for Children with Special Health Care Needs; and 20.2% is earmarked for women, maternal, perinatal infants.

Other's category includes Title V operational costs, Public Health Services and Systems Capacity. Title V leadership will hold budget discussions throughout the fiscal year (in coordination with the DOH Finance Division, ASG Budget and Treasury Analysts) to address any new or unplanned MCH needs.

Form 2

ASMCH Title V will continue to closely monitor budget and expenditures regularly to ensure compliance with legislative financial requirements. FY2022 budget meets the required Title V state match which is a $3 match in non-federal funds for every $4 of federal Title V funds. Majority of American Samoa's local match continues to be in-kind appropriations. ASMCH "Local MCH Funds" (Form 2, line 3) of $390,000 —which is also considered the state's applied Maintenance of Effort for Title V—is composed of local funds from Title V staff salaries and also in-kind match of the following ASG personnel and office/clinic facilities: MCH clinics at ASCHC; Central Well Baby clinic and local funded nurses, Nursing administration office; DOH Finance office and staff, ASG Budget Office and Budget Analyst Lomialagi Seumanutafa ; ASG Treasury office and Treasury Analyst, Tolua Tavai; Procurement Office and staff, Shirley Laula at Purchasing Division and Lucy Leota at Contracts Division; and this includes all their utilities at well. The majority of this match (approximately 79%) is related to operational costs, needs assessment and public health services . Along with other federal funds, these state MCH dollars provide a critical component of American Samoa's MCH infrastructure.

Form 3

Each year, ASMCH Title V administrative staff completes an extensive assessment of "Types of Individuals Served" and "Types of Services" provided by Title V funding at the state and local level, as reflected in Form 3a and 3b, respectively. Title V funds support essential services as identified in the Title V MCH Pyramid of Services (i.e., direct services, enabling services, and public health services and systems). Budget categories reflecting the Pyramid of Services categories will be generated manually by the Program Coordinator in order to keep track of all credits and expended services. Additionally, ASMCH staff are required to set up work plans and activities based on both the NPM/SPM and service categories. For state level activities, all state Title V budgets and expenditures are assessed to determine where activities fall in the Pyramid of Services.

A well-known example is the state priority to Reduce Rheumatic Fever and Rheumatic Heart Disease. It aligns with the top, the middle (enabling services) and bottom level (public health services and systems) of the pyramid through NPM 10 and NPM 11, respectively. State level activities for NPM 10 (Wellness visits for Adolescent) focus on wellness visits and NPM is promoting children accessing medical homes. The school screening program for RHD

will both increase access to medical homes as well as promote preventive medical services for children and adolescents.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: American Samoa

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Program Purpose and Design 2020

Title V in American Samoa covers an extensive range of health initiatives towards improving the health of the MCH population. Focusing on comprehensive systems and structured delivery of healthcare to meet the needs of the people in the territory, ASMCH thrives on advocating for these changes to benefit the women and children of American Samoa. Like many of the other pacific jurisdictions under Region IX, ASMCH is similar but also unique in its own design and purpose.

Title V continues to operate entirely under the guidance of the Health Department, under the leadership of the Director of Health and his deputies. This is a change since the beginning of 2020, as ASMCH was placed under the Nursing Division before and was guided by the Nursing Director. As more responsibilities have been expected from the Nursing Division since COVID19, this change was decided by the local DOH leadership to allow both ASMCH and Nursing to continue growing in their own respective lanes and to thoroughly serve the community through its program objectives. Although this has been the origin of the Title V program from its inception to the present day, the bulk of the MCH staff who are non-clinical continue to strengthen collaboration with the clinical staff funded under Title V on a daily basis. This linkage of clinical and non-clinical personnel creates a connection of insights from a programmatic perspective, directly linking public health services and enabling services to clinical work. This helps the Title V program review efforts that can help bridge existing gaps in the system, and advocate for changes that improve care for its population.

Title V is also very active in community and governmental partnerships that target women and children. Title V represents not just a health perspective, but also an overall system change attitude that benefits entire populations and not just a few. Title V advocates for family involvement and supports recommendations voiced by families that are significant to changes within the system of care. Title V has been proactive with lawmakers, keeping them informed about issues that affect women and children and how they can assist through their work in these efforts.

Through various ways, Title V has been instrumental in connecting people, programs, systems, and organizations. When opportunities arise, Title V provides informational sessions on current trends regarding improving systems of care, updating service providers on latest options that are evidence-based and standardized for assessments and approaches. Programs are connected in a way to complement each other while at the same time improving their services for the MCH population. In the past year, ASMCH has been instrumental in reinforcing collaborations among mental and behavioral health services for young teens and adolescents. ASMCH was instrumental in using telehealth as a means to create a system within the territory that all partners can utilize when addressing teen suicide. Data systems are examined to determine best approaches for dissemination, assessment and interpretation. And organizations have a better understanding of where we all relate to one another, to better serve our community.

Title V is unique in the sense that although we are structured to follow the same layout as many of our counterparts in the US mainland and around the pacific for state priorities, we also have the flexibility to design our interventions and approaches to suit our cultural expectations and context. Such approaches include collaborations with village groups and the office of Samoan Affairs where village mayors are employed. The village mayors are asked to support outreach programs and screening projects that are led by Health officials, and to gather villagers to participate through their village patrol systems. Through the help of the clergy, sometimes, churches are targeted to address larger populations for dissemination of information, as religion is a priority for many local families. Women's groups

within villages or churches are also great avenues that health messages and talks are usually delivered.

These are approaches that have been utilized in the past and are still very much effective today. These methods have proven to be more efficient due to the way the Samoan culture, family unit, and way of life is structured. ASMCH team supports all these efforts to ensure targeted populations have access to preventive measures amidst this pandemic crisis.

Since the existence of the Leo o Aiga Health Information Center and its close relationship with ASMCH Title V, the focus on families have seriously been amplified across the action plan for this funding cycle. More focus on family perspective and how to meet their most critical needs during a pandemic have been paramount in the work ASMCH is currently engaged in. Families provide a source of understanding that many agencies and services have lost perspective on, therefore leading to non-purposeful and meaningless efforts.

By carefully listening to individual families and their stories, we are able to grasp a much broader understanding of where support is needed and the types of services that will fulfill these pertinent needs. Often times, the health concerns become secondary to other existing issues that hinder an overall wellbeing for many families. ASMCH program often is challenged to think "*outside the box*" and creatively determine other ways to assist families but are still very much part of the existing system.

ASMCH Title V and its programs, along with the Family-to-Family Health Information Center (Leo o Aiga) are paying more attention to local families and their stories. These stories help strengthen our focus in carrying out strategies outlined in the State Action Plan that will produce meaningful and purposeful outcomes for the individual, the family, and the entire community.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

MCH Workforce Development 2020-2021

Presently, the Maternal Child Health Program continues to experience challenges with having a workforce that is capable of handling all program responsibilities in a well-organized way, more so with COVID19 and the demands it brings. The challenges have been thus far “eye-opening” to the reality that we will continually be in “survival” mode until we are clear with this pandemic. Survival mode in our definition means plainly that we will support all means to keep COVID out of our territory because we cannot afford to have one case.

Overall, there are approximately 13 DOH employees who work directly under the umbrella of ASMCH, with one vacant position. These employees are either fully or partially funded by Title V grant monies. There are 3 staff members under the Leo o Aiga Center and one paid under SSDI, which all contribute to Title V overall priorities for our women and children. These staff members also were all deeply involved with COVID measures and efforts across the year 2020 and into the present.

A mixture of clinicians and support staff define the combination of the Title V Workforce on the island. Clinical personnel are housed under the community health centers to provide direct healthcare services while supporting and administration staff focus on providing support for programmatic efforts. It should also be mentioned that parts of the ASMCH workforce are financed by the local government to meet some of the matching requirements per the Title V grant.

Although a few of the MCH team had resigned for various reasons, the program has learned from previous years to be consistent on following up with hiring of vacant positions so that services and programmatic efforts are not delayed due to shortage of staff. Despite the lengthy hiring process, the program has managed to attract capable and dedicated individuals who are passionate about the work we do. Of the current staff, these Title V employees also have been asked to support current ongoing COVID prevention efforts across Public Health initiatives. Some of these efforts include COVID testing, border support for incoming vessels (air and sea ports), data collection on vaccinations, media support to educate the public on social distancing, hand hygiene, and properly wearing masks, and supporting quarantine management. These efforts may or may not directly relate to MCH populations but significantly impacts the health of the community as a whole. Ideally, it would be most beneficial if all 13 employees would work full time on MCH initiatives; however, supporting overall health objectives for the department continues to be most valuable and significant to the operations of MCH.

Of those working full time on MCH priorities, 2 are seasoned health educators with backgrounds as Nurse Assistants. They are assigned to the Health Centers to provide health education during the prenatal and well-baby clinics, as well as to the OBGYN clinic and maternity ward at the LBJ Hospital. They are Mrs. Conference Alailefaleula and Mrs. Manulelei Silva-Aitaoto. Both health educators also were sent for an off-island training on breastfeeding, as Lactation Counselors. One passed her examination while the other is continuing to make progress and preparation for the next testing opportunity. This trip was made possible by Title V funds. This same individual recently passed her Licensed Practical Nurse (LPN) exam and is now currently working as an LPN, supporting the demand for nurses across the island. Although we are supportive and delighted for this change, we are also aware that Title V goals for prenatal and well-baby health education in the clinic through this service will become second to the demand for nursing services.

Some of the challenges in regards to workforce prompted by the demands of COVID operations are the constant requests from leadership to support the overall needs of the department through “loaning” some of our team

members for a particular amount of time for assigned DOH projects. ASMCH has been accommodating to these requests, but has also been very vigilant in informing the DOH leadership when these team members need to be retained under MCH work to meet the program requirements and serve its specific populations. There are other newly established grant programs that have also requested to acquire some of our team members due to their professionalism and the degree of work they produced, harnessing the support of DOH leadership, but we have maintained our grounds to argue that the populations we serve and the purpose of Title V goals is just as important as of the other DOH programs.

The MCH Data Technician, Ms. Ruta Ropeti, has an Associate of Science Degree from the local community college and also most recently completed all courses required for the Data for Decision Making (DDM) Certificate to become an EpiTech. Ms. Mata'uitafa Fai'ai who was our Title V Epidemiologist holds a Master's in Public Health with an emphasis on Epidemiological work. Ms. Fai'ai has assisted in teaching EpiTech courses for our local public health workforce and has had extensive experience with health projects in American Samoa addressing women's health, actively involving herself in data collection, interpretation, and dissemination. Both employees have been heavily involved with DOH projects which required data support personnel. They continue to participate in Department wide functions and projects that need assistance with data. Ms. Mata'u was also serving as a part time Epidemiologist for the MIECHV program. At present, Ms. Mata'u has departed the territory to pursue her doctorate in Epidemiology while Ruta has started an LPN program at the local community college.

The MCH Coordinator, Anaise Uso, has worked as a Dentist for the past 18 years, and has extensive experience in school-based preventive dental care for young children. Since her appointment to coordinate the MCH Program, she spends all her time managing MCH, SSDI, and Zika efforts, to say the least. Dr. Uso also participates in Dental activities throughout the year and is a strong advocate for preventive dental work for young children. Dr. Uso continues to serve the DOH through several avenues, one of which is telehealth. She is deeply involved in Others include support within the Command Post during outbreaks and pandemics locally. Presently, Dr. Uso is one of the core team members for DOH COVID efforts, she is heavily involved in meetings, community projects, and island-wide efforts to protect American Samoa from COVID. She is also working to support DOH by testing, vaccinating, managing social media communications, mass media productions, workforce training, and all other efforts directed by DOH leadership.

Assisting the MCH coordinator is her colleague, Ipuniuesea Eliapo-Unutoa, who has also worked for MCH for about two decades, primarily with the CYSHCN program and the newly assigned Rheumatic Heart Disease (RHD) Control & Prevention Program. Ipu, as many call her, also has used some of her time in the past year to manage the Preventive Health & Health Services Block Grant. Ipu is also the Project Director for the newly acquired Family to Family Health Information Center (F2FHIC) for American Samoa called "Leo o Aiga", as she is also a mother of a child with special needs and has been in the forefront in attaining this assistance for families of CYSHCN in Am. Samoa. Her background is in Occupational Therapy; however, she spends all of her time performing administrative responsibilities for Title V, F2FHIC, and RHD.

At the beginning of 2020, Ms. Margaret Sesepasara was continually the Title V program director. Before borders closed for American Samoa, Ms. Margaret had to travel off-island for family obligations. The expectation was for her to return within a few weeks but due to COVID and border closure, the Title V Program Director was unable to return to the territory until recently. Her absence and the lack of communication for the time she was away had reinforced our leadership to assign Title V under the Deputy Director of the Department for all matters up to the present day. And due to constant changes with COVID operations, this arrangement is currently where Title V stands.

Ms. Margaret Sesepasara, a nurse practitioner by profession for over 40 years in DOH, is still the Director of Nursing

and is fully funded under Title V. She, along with a colleague who is also a Nurse Practitioner, Mrs. Tele Hill, has worked for MCH and Department of Health for more than 40 years. They provide clinical support within the prenatal and Well-Baby clinics at the satellite health centers, as well as home-visitations for the Elderly, the chronically ill, and children with special needs population per referral requests. A registered nurse who is also funded by MCH Title V during 2019, works in the Health Centers primarily with the Well Child Clinics, and also assists with RHD Bicillin Clinics. This nurse also plays a huge role in DOH outreaches and mass drug administrations.

Staff recruitment and retention is a challenge for MCH among other things. With the new government, pay adjustments have been processed to meet the rising cost of living for the workforce as well as compensation for almost a decade without increments or pay raises. This has been a positive component from the new administration for employees who have worked in the government for at least a decade. The hiring process through the government is extremely frustrating and lengthy, affecting recruitment of the most qualified applicants. Most often, applicants with clinical training are preferred to those without a clinical background. This is to accommodate shortages of clinical support when the need arises; however then, programs lack support and personnel therefore causing efforts from the program side to be pushed aside to be second priority.

MCH staff takes advantage of training opportunities that promote skill advancement for the work they perform daily. Title V team have had the opportunity to be trained on becoming suicide hotline operators, manning the lines after hours but also using these skills when they work with MCH clients. Other trainings in which MCH staff was involved with were all related to COVID efforts. For example, some were recruited to train in contact-tracing, if COVID was to become present in our territory and how DOH was to manage these cases. Others were asked to be trained to assist in supporting border patrol and screening, data input and screening at vaccination sites, and all other COVID efforts.

Challenges will continue to exist in the MCH workforce. With limited funding to support additional staffing, the existing workforce has and will continue to learn to assist one another in addressing priority needs. Cross training has been a continued strength of the ASMCH team, specifically when it calls for public outreach, island-wide emergency responses to natural disasters and pandemics, and departmental activities. The Title V team has learned to support one another by learning each other's work and being able to step in to cover when it is needed. The leaders of DOH highly regard the Title V team when it comes to supporting overall DOH missions.

In moving forward, prioritization of recruitment and retention is necessary to reach goals for the following years. MCH leaders continue to assess and adjust compensation for additional skills and years of experience across the workforce. We continue to propose to convert employees from contract to career service status as a sense of security and commitment for our program staff. MCH leaders continue to also integrate the entire staff into being more involved with the application process for Title V, designating specific roles and responsibilities per their assigned job descriptions within the program. This has helped increase their perception on the Title V program objectives and has given them more opportunities to provide input on the application and proposed plan.

Staff retreats have also been implemented to help with team building skills, time away from the office so that team members can focus on how to best work with each other while providing exceptional and meaningful service to the public. And lastly, conducting periodic evaluations on work performance and providing constructive feedback to improve on personal and professional growth is on a continual basis.

III.E.2.b.ii. Family Partnership

A. Advisory Committees

Family involvement in MCH led advisory groups are very significant in many ways. In the past year, family representatives from different backgrounds and economic statuses contributed their knowledge to the community's evolving needs on healthcare and overall social issues that impact the overall health and wellness of a family unit. Parents and Caregivers were also heavily involved in advisory groups such as the Rheumatic Heart Disease Advisory group, where more than one parent was a member. Family Involvement in these committees made a loud statement to the professional community that we need to consider family input because it is vital in our efforts to improve services and care. Professionals were recognizing that family input is necessary in the life course of every human being.

ASMCH understands that a one-parent/family perspective does not comprehensively represent the variations of experiences that we need to cause better outcomes in services for women and children. Therefore, ASMCH has been advocating for more family representation across the many advisory groups for women and children, as well as children with special needs, to integrate their valuable input.

B. Strategic and Program Planning

Family Representatives have been instrumental in all sectors of MCH this past year, contributing to strategic plans and program efforts. Opportunities allowed families of women, children, and children with special needs to provide input that were valuable to improving services and healthcare delivery for themselves and their loved ones. Parents and consumers (pregnant and breastfeeding mothers) contributed in stakeholder meetings, sharing their perspectives in strategic planning for MCH priorities. Families of children with special healthcare needs were encouraged to share their stories about the challenges they face daily, which are commonly overlooked by service providers and agencies, yet are in much need to be addressed.

Common themes that were echoed across interviews and parent group meetings were marked with great consideration as it noted issues that should be addressed as priorities, if not already considered. Without these insights, it would be challenging to meet the specific needs of the community.

C. Quality Improvement

Despite restrictions initially presented in 2020 by COVID, there were a few opportunities that enabled ASMCH to collect feedback from community and family members regarding COVID preventive measures across the island. Families were asked to call a hotline to ask questions or inquiry about services that were available to the public. Information was made available on social media and local radio to keep families informed at all times.

When in-person meetings were allowed, trainings prompted opportunities for families to provide feedback on how to improve on the quality of services to aim for better outcomes. Families shared in groups, and in person to ASMCH staff as well as participating in the national children’s survey, to provide valuable insight on what needs to be done better and how to do things better.

Although we are COVID free in American Samoa, ASMCH took the lead to be a part of the Department of Health's initiatives in promoting preventive measures for the public to be aware of during these difficult times. ASMCH have also assisted in promoting measures to keep safe from COVID19 if ever it became a reality on island. The community was consistently reminded to practice social distancing, get vaccinated if eligible, good hand hygiene practices, balanced nutrition, and being physically active.

D. Workforce Development and Training

ASMCH was able to implement a few parent workshops throughout 2020 despite uncertainties with COVID19. Families of children diagnosed or suspected to be on the Autism Spectrum Disorder were gathered to initiate conversation about support and how to advocate for better health outcomes for their children. This was also a learning opportunity for the ASMCH staff who have very limited experience and expert knowledge about working with families of children on the spectrum. This meeting prompted an increasing interest for families to seek out other families and share experiences and resources, as well as service providers gaining better understanding of how to best work with different families. ASMCH staff was challenged to lead these groups and develop a sense of comfort for families to trust in their professionalism and their efforts to help them.

ASMCH also draws a strong connection with other family-led non-profits in the community. Since the start of COVID, technology and social media were encouraged to be means of connecting if there were to be a spread of COVID in the community. Trainings were offered for families to learn how to use their smart gadgets to connect to the outside world. Families were interested and attended trainings offered through a partnership between ASMCH, the Leo o Aiga Center, and the non-profits for families in the community.

Ongoing zoom calls between federal partners and the local MCH team contributed to the increased knowledge of utilizing telehealth to continue local efforts and implementing strategies that were already in place for the State Action Plan. ASMCH workforce also were very involved with all aspects of the local COVID19 response efforts across the year. From protecting frontlines of the borders to vaccination efforts and quarantining manpower, the local MCH team were on the forefront and were heavily involved to assure all efforts were successful. ASMCH staff was also keen on making efforts to attend most, if not all, of the training hosted by its partners, government agencies, and Departmental workforce development. Majority of these development training teaches staff on how to be more proactive for families of children with disabilities. Local specialists were also recruited to conduct Inservice training regarding healthcare system navigation.

E. Block Grant Development and Review

Input from family members were gathered collectively through phone interviews, home visitations, and other opportunities that coincided with COVID restrictions during 2020. Families were given

F. Materials Development

Families play a huge role in the development of materials and health literacy within MCH. Families are asked to comment and make necessary recommendations on brochures, banners, pamphlets, and other available reading materials for review. Materials are produced in both Samoan and easy English language to accommodate the community. Families are encouraged to provide input on what they feel is essential to be included in materials to convey the message to the community.

Family Stories are also told through media productions that deliver specific messages that are pertinent to the health and wellbeing of women, pregnant women, infants and children, and children with special needs. These media productions have become very effective in spreading awareness on MCH initiatives within our community, especially during these COVID times.

G. Program Outreach and Awareness

ASMCH has been involved in the few outreaches that were possible during the COVID pandemic. Such outreaches include governmental functions that involved health booths out in the communities to promote awareness on COVID

as well as vaccinations. Parents and Family Representatives are invited to join MCH at these functions to talk to other family members who may have questions or concerns that only a family member can relate to and share pertinent information about MCH and its purpose in the community. Parent Representatives are asked to go on local television programs with MCH staff to discuss breastfeeding, RHD, prenatal care, and children with special healthcare needs.

The ASMCH have taken the opportunity along with other DOH program to conduct mass media production to promote different programs and their mission within the DOH. This initiative has been in place to allow the community to know about different services offered by DOH.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

MCH Epidemiology Workforce

Epidemiology Workforce is critical in the public health arena to identify threats to the health of the community. In American Samoa, this is a rare position as there are not many epidemiologists locally. In the Department of Health itself, there are only two Epidemiologists. One works for the Department having oversight over all epidemiological work and ELC (Epidemiology and Laboratory Capacity) grant operations while the other was hired directly under the shared responsibility of the MCH Title V program and the MIECHV program. However, since the start of COVID operations and the demands of the operations, both staff have been on the forefront gathering data and strategizing with the COVID task force and the entire government on how to continue keeping the island COVID free.

Also, it is important to mention that in the past several years, ASDOH leaders supported efforts to conduct training for local DOH employees to learn how to work with data and how to use collected data to make informed decisions. A serious of five modules was laid out across the span of a few years, taught by instructors locally and off-island from the support of the Pacific Island Health Officers Association (PIHOA). Once completed, the staff will receive a certificate of completion from the Fiji National University and considered as a certified Epidemiology Technician (EpiTech). Presently, two of MCH Title V staff have fully completed this training and have received their certificates, while a few more are waiting to complete modules before receiving a certificate. This training has definitely increased the capacity of the Title V team to work and understand data as it relates to the State Action Plan and selected priorities.

At present, the Epidemiologist that was hired to assist with Title V work has left the island to pursue a doctorate in the same discipline. There is no pool of professionals locally to fill this gap, however, we continue to rely on our Title V EpiTechs and consult with the one Epidemiologist left on island as well as the Epidemiologists we are familiar with across the pacific jurisdiction to help us with our work.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The availability of SSDI funds has enable ASMCH Title V to develop, enhance, and expand data capacity to execute annual needs assessment activities and performance measure reporting requirements in the MCH Block Grant. Such enhanced MCH data capacity enables ASMCH and its key stakeholders to engage in informed decision-making and resource allocation that supports effective, efficient and quality services for women, infants, children, including CSHCN, and their families. SSDI complements the MCH Block Grant by improving the availability, timeliness, and quality of MCH data. Utilization of these data is instrumental to program assessment, planning, implementation, and evaluation efforts, along with related investments, in the yearly MCH Block Grant Application/Annual Report.

The decision to have a Cross-cutting Population Domain for American Samoa was based on the need to address Title V priority specifically focused on data systems and infrastructure arose from the ongoing commitment of ASMCH to ensure evidence-based practice and data-driven decision-making. The state action plan for this priority covers two broad goals that are strongly tied to the SSDI goals and objectives, including improving data infrastructure and systems, increasing epidemiologic production and use, and forging partnerships that improve data capacity and infrastructure.

As documented on Form 12, certain strengths are obvious in timely reporting of births in the SILAS database. Current partnerships with Newborn Babies Hear ensures accessibility to birth records as soon as they are entered in SILAS. Whereas Vital Death Records for 2020 are currently being entered into SILAS and may not be complete until December 2021. Certain databases ASMCH is not yet linked to, such as WIC and Medicaid, may need to be included in a revised IAA with these two agencies in FY2022.

Current SSDI goals and objectives align with Title V data capacity priorities, enabling ongoing Title V program assessment, monitoring and reporting:

Goal 1: Build and expand MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in ASMCH, including assessment, planning, implementation, and evaluation.

Objectives 1.1: The MCH Data Matrix will be updated with all NPMs, SPMs, and NOMs and reported quarterly by the MCH Title V Program to Program Director and key partners via emails and hard copies.

Objectives 1.2: All quarterly reports will be compiled and the data matrix will be updated and presented to the MCH Data Core Workgroup by the end of May, annually.

Objectives 1.3: Key Partners meet twice a year to review and assess key findings on state priorities and update program activities.

Objectives 1.4: A factsheet with past year data dashboard is included in the executive summary of the Title V annual report and application and disseminated to other partners and the community for feedback.

Goal 2: Provide partnership and on-site support for the development and implementation of a data collection tool/process that will enable tracking of Title V MCH Block Grant National Performance Measure (NPM) data.

Objectives 2.1 Build upon completed Standard Operating Procedures for Data collection and reporting.

Objectives 2.2 Assist the Public Health Surveillance office to link MCH to the SILAS program Helping Babies Hear is utilizing to produce an electronic birth defect registry.

Current SSDI Project funds a fulltime Data Tech Ms. Ruta Ropeti, who most recently passed her Field Epidemiology Tech Certification. She worked closely with MCH Epidemiology, Ms. Mata'uitafa Faiai to ensure SSDI Core Data Sets are updated quarterly and disseminate findings in a timely manner to evaluate progress and advance data-driven initiatives. In 2020, these core data sets were instrumental in conducting the Five-Year Needs Assessment and assist prioritizing health disparities for ASMCH Title V to target for 2021-2025.

The ASDOH Public Health Surveillance Office is managed by Dr. Aifili John Tufa, who oversees all Epidemiological efforts including reportable disease surveillance, syndromic surveillance, collecting vital records, validating UDS data and other program data. This office also administers BRFSS and is responsible for all DOH Data Surveillance oversight. ASMCH Epi team works closely with Dr. Tufa for epidemiologic support to ensure ongoing Title V needs assessment are carried out accordingly and data is collected in a timely manner. This past year was challenging because of Measles Outbreak and COVID-19 pandemic. Most data capacity activities were canceled or rescheduled due to social restrictions. Data that was routinely collected such as Vital Stats Death certificates and was put on hold for a while because ASMCH staff members were assigned to other stations to support the department mission.

Having direct and timely access to MCH health data is another important component of the Title V performance monitoring process. American Samoa Vital Records files (Live Birth, Fetal Death, linked infant death/live birth files, linked Maternal Mortality Files) and other data sources are collected by the Public Health Surveillance office, and oversee by the ASDOH Epidemiologist. As part of the American Samoa SSDI project, the Data Tech routinely collects and reports on certain MCH Health Indicators and reports to the MCH Epi, who then informs clinical supervisors on these findings and recommendations made to improve these irregularities. Clinical in-service trainings are then implemented to improve documentation and clinical capacity. Example; providing surveillance over delivery and birth records, analyzed, interpreted and communicated not only to Title V staff but to MCH stakeholders working to reduce infant mortality and other adverse birth outcomes. SSDI initiative fosters timely data collection, identify needs for quality improvement projects and provides recommendations to improve on these findings.

Even with the large number of linked data files that are currently available to ASMCH, there is always room to expand on current data capacity. Various programs in a collaborative effort are working closely with the MCH Epi team, CSHCN Client Navigators, Helping Hands Early Intervention and Newborn Hearing EDHI program to see how programs can maximize utilizing the EHDI web-based data reporting system SILAS to assist in monitoring and generating data reports on a regular basis. This will assist in the possibility of establishing several new MCH-related data linkages, including Birth Defects Registry data linked to EDHI, Early Intervention, CSHCN, Immunizations and Vital Records. It is ASMCH's long term goal to have MIECHV, WIC and Medicaid link into the SILAS system as well. This will assist to improve the timeliness of data extraction and reporting especially if linked between Birth Defects Registry, Zika Registry, birth and death certificate data.

Both SSDI and MCH- Zika Services grants had cost-shared the building of MCH reporting templates and Ad Hoc reports on SILAS. Reports generate about 50% of all MCH Title V NPM, NOMs and ESMs. It is in the plans, to continue working with Family Trac, the owner and administrator of SILAS to build the RHD registry in the next 12 months as well as generate more ad hoc reports to populate majority of data that's left if not all.

Half of the American Samoa SSDI grant funded the very first MCH Title V Jurisdictional Survey in American Samoa in 2019 and again a second one completed this past month, July 2021. Data from the Jurisdictional Survey is definitely beneficial to small island jurisdictions like American Samoa who can now have some data trends to compare and make informed decisions based on key findings and data trends.

Other MCH Data Capacity Efforts

To support MCH Data collection and capacity, there are additional systems in place to assist with these efforts. To date, the Leo o Aiga center has developed an online system that tracks enrolled families of clients in the program and the services they receive from the center. This system is also accessible to the CYSHCN program staff so there is a consistent sharing of information between the two program who serve the same families and individuals. This system records basic family information of the individual with special needs and the different services they receive from the Leo o Aiga center. The Program continually works with the developer to update necessary changes pertinent to the growth of the program and the its clientele.

Also, the ASMCH team relies heavily on data reported by the Unified Data System (UDS) used by the Community Health Centers (CHC) in the territory. Throughout the year, the data personnel at the CHCs contact MCH leaders to help them update and revise encounters forms that are used on UDS to collect information on services provided for women and children across the island. These encounter forms collect data on demographics, basic health information, vitals, and related services such as behavioral counseling to address smoking and drug use. The UDS system also collects data from the Rheumatic Heart Disease Bicillin clinic for all children receiving prophylaxis to prevent heart complications.

ASMCH leaders and staff also were involved in the planning phase for the national survey, through zoom calls with the contractor and federal partners to plan for implementation in the current year. Details were discussed regarding some expected and unexpected changes due to the pandemic and how it may impact the implementation of the survey. The survey was completed a few months ago by trained locals who were also involved with the survey two years prior.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

American Samoa has experienced various public health emergencies in past years, including natural disasters and disease outbreaks. Title V program is often called to provide leadership and support in delivering critical MCH services during these emergencies, assisting local communities to respond to emergency threats and needs. Past natural disasters included the 2009 Tsunami, various tropical cyclones such as Hurricane Val and Gita. All produced catastrophic results; displacing many families from their homes; lives lost; businesses, plantations and government buildings damaged. American Samoa has also experience major disease outbreaks. Within the past 8 years, AS has faced a Zika outbreak in 2016, Dengue outbreak in 2017, Measles outbreak in 2019 and most recently the COVID-19 pandemic in 2020 to this day.

MCH Title V role during these emergencies ranged from risk communication, data surveillance, car coordination, community needs assessment, and supporting medical services. MCH Title V was and continue to be proactive in the territorial emergency preparedness planning and coordination with partners during disease outbreaks and assist in mitigating preventive and control measures to ensure the needs of its MCH population are identified and addressed.

The Department of Health Emergency Preparedness and Response Division (EPRD), formerly known as the Public Health Emergency and Preparedness Program (PHEP), conduct quarterly meetings with its Healthcare partners to review and update the State Emergency Operating Plan when there is no emergency. During an emergency, healthcare partners meet monthly to review and report on lessons learned, plan for and conduct drills and tabletop exercises to improve emergency response and mitigation plans. The purpose of the Healthcare EOP is to outline SOPs on how to mitigate public health and medical assistance in response to a disaster, emergency or incident that may lead to a public health, medical, behavioral, or human service emergency.

The MCH Title V has a responsibility to review and provide recommendations to EPRD on their EOP depending on what type of public health incident it may be. Natural disaster EOP does address at-risk and medically vulnerable pregnant women, infants and homebound population. Mostly to ensure they are evacuated to adequate shelters if needed and also to ensure they have basic needs such as medication, water and food.

Title V does not play a role in the Incident Command Structure unless populations affected are women and children such as the Zika Outbreak. Because the MCH Title V Program Manager has vast experience with Risk Communication during Zika and Measles Outbreak, she is now the Media Liaison in the Incident Health Command for COVID-19.

The MCH Title V is now part of the EPRD's healthcare partners and their monthly meetings. An invitation was received recently to join the September 2021 monthly meeting. This will ensure opportunities for having close-up involvement in the planning and development of the State's EOP. The Title V leadership was never included in past emergency preparedness planning before a disaster but is actually brought in for consultation once the UHC is activated.

Based on ongoing public health and Title V program needs assessment efforts and lessons learned from previous emergency responses such as Zika and the most recent Measles outbreak, critical gaps in emergency preparedness and/or surveillance data were identified. Best practices from lessons learned and recommendations made in past disasters are now being utilized to produce favorable outcomes during the COVID-19 pandemic response. The territorial has two Epidemiology experts in American Samoa who are instrumental in providing timely data. Actively utilizing the Pacific Syndromic Surveillance data reports enable American Samoa to close its borders early, boost its vaccination coverage and contain the Measles outbreak with no fatalities. Revised EOP and lessons

learnt from that outbreak is now keeping American Samoa safe during this COVID-19 pandemic and remains COVID free.

American Samoa Title V program recently participated in the third cohort of the Emergency Preparedness and Response Action Learning Collaborative. A joint learning collaborative by AMCHP's Workforce Development and Capacity Building Division and CDC's Division of Reproductive Health. It was a programmatic, immersive activity featuring multiple didactic trainings, peer networking sessions, and applied team building with facilitated coaching support. Dr Haley Cash, a well-known NCD Epidemiologist working with USAPIs was one of the mentors. CNMI and Guam were also part of this learning cohort.

The framework utilized in this learning cohort for the maternal and infant emergency preparedness and response (EPR) plan at the state/territorial level includes all of the following strategies:

1. Integrate MCH considerations into state EPR Plan
2. Develop strategies to gather epidemiologic/surveillance data on women of reproductive age and infants to guide action
3. Establish/promote EPR communication about target population with clinical partners, public health and governmental partners, and with the general public
4. Identify public health programs, interventions, and policies to protect/promote health and prevent disease and injury in emergencies among maternal and infant populations

Certain recommendations were identified during the coaching sessions with Dr. Cash and Ms. Rica Dela Cruz. Title V will work closely with EPRD starting with next month's healthcare partners' meeting to ensure these recommendations are carried out.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

HEALTHCARE DELIVERY SYSTEM 2020

The Health care system in American Samoa consists of the following:

1. LBJ Tropical Medical Center
    a. OBGYN Clinic
    b. Pediatric Clinic
    c. Family Planning
2. Department of Health
    a. Federally Qualified Community Health Centers
    b. Federally funded health programs targeting Communicable & Non-Communicable Diseases, and Preventative Programs
3. Veterans Affairs Outpatient Clinic
4. Medicaid Program
    a. Off-island Referrals
    b. Provide funding for American Samoa's Health care system
5. Non-profit organizations
    a. Rise
    b. Teen Challenge
    c. Hope House
    d. Intersections
    e. Alliance

American Samoa has multiple services that cater to different age groups within the island's population. The Maternal and Child Health (MCH) program utilizes each of these services to ensure clients receive the most reliable health care available on the island. The existing Healthcare Delivery System between MCH and its private/public partners continuously evolve as quality care within the healthcare system progresses.

MCH Title V provides healthcare services to women of child-bearing age, pregnant women, infants, children and adolescents, including children and youth with special health care needs. Women of Child-bearing age are encouraged to visit the Prenatal clinic at the Community Health Center or the Family Planning Program at LBJ to receive preventative healthcare services. MCH staff at the health centers offer educational classes to promote healthy habits and lifestyle for these women. They also ensure that these young women understand the value and impact of their present lifestyle decisions may have long term repercussions on their overall health and the health of their future children. Such lifestyle choices as being proactive about not smoking or drinking will greatly contribute to their wellness in the future. The Family Planning program at LBJ offer abstinence and sex education, a variety of contraceptives, consultation, and various tastings. Family planning is only offered at the hospital and may not be easily accessible to women who live farther from the hospital. Contraceptive methods are not available at the Community Health Centers as it had been previously through the Zika Grant.

Family Planning services are being led and implemented by the LBJ Medical Center who is the grantee for Title X. Women are referred to either clinic depending on preference and convenience. The LBJ Medical Center offers a variety of services versus the Tafuna Health Clinic which is accessible to many women in the community but has limited options of contraceptives available.

The healthcare delivery system for pregnant women is one of the more established systems within the island's healthcare. The MCH staff partner with MIECHV to enroll young, high-risk, first-time mothers to receive their services. MIECHV provides home visitation services wherein educational information and empowerment are imparted on young pregnant women. This helps young, soon to be mothers feel more comfortable and confident in taking care of their baby after delivery. MIECHV also provides their services within the CHC clinics, educating pregnant women that are there for appointments and serving their clients.

Upon initial visit of pregnant women within the LBJ or the CHC clinics, they get tested to confirm they are pregnant. The CHC clinics schedule monthly checkups to monitor the health of the growing fetus as well as the mom. Pregnant women are usually scheduled for monthly visits at their health centers unless there are complications or pain throughout the pregnancy period. Under these circumstances will the pregnant woman be scheduled to see the OBGYN doctor at LBJ before labor and delivery.

Labor and delivery for pregnant women is carried out in the LBJ hospital. When women are nearing their term, they have much more frequent visits with their doctor to help closely monitor the health of the mom and baby. When a pregnant woman has given birth, depending on whether there were complications or not, the infant can be referred to the different programs within MCH and DOH.

Once pregnant women have given birth, nurses within the Maternity Ward and Nursery fill out Well-Baby and Postpartum cards with newborn and mothers' information. MCH staff collect these cards on a weekly basis in order to enter data within the system in a timely manner. These cards are also used by MCH staff to give reminder calls to mothers for their newborn appointments, as well as theirs.

As newborns continue to grow, MCH services are implemented within the CHC Clinics to cater and to identify children and youth that may benefit from MCH program services. Whenever children receive checkups or their immunization shots, the well-baby doctors or nurses screen these children for developmental delays, as well as for Rheumatic Heart Disease if a child has a history of having the strep infection. If screenings show that a child has a developmental delay or Rheumatic Heart Disease, clinicians will refer the child to the MCH staff to receive the necessary services and support.

Title V programs cater to infants, children and youth, including children and youth with special needs who are referred for specific services that are available in this program. Children who are found to have streptococcus infection and report symptoms of sore throats, fever, and joint pain are screened and registered into the bicillin prophylaxis program at the health centers. The children receive this medicine to prevent their heart valves from further damage until advised otherwise by visiting pediatric cardiologists.

Adolescents are usually seen at the physical clinics once a requirement for a health examination is needed to participate in a school sport or activity, as well as entrance to college or the military. Teenage suicide is a serious problem here as well as drug abuse, therefore Tittle V partners with the DOH Behavioral Health Program, Department of Social Services, LBJ Hospital, and non-profit organizations to address these problems effectively as a team.

Children with special health needs are typically identified through well child checks or through families who are noticing something is not "normal" with their development. These children get referred to the early intervention program and the helping babies hear program initially for a battery of assessments and tools to screen for baseline data determining the developmental goals for the family and the professionals to work on. These children then are referred to Title V services for follow up, family support and other support services that are needed.

For children and adolescents who were self-referred, the CYSHCN and Leo o Aiga Center staff work together to gather information from the family to create a plan to meet the needs of the individual and make necessary referrals to all services available at other existing programs. Most often, families prefer to gain assistance in searching for a recreational or vocational purpose for the individual with special needs after they complete the Special Education Program, and the CYSHCN staff works alongside families to provide this support. Nevertheless, healthcare is always a priority in these plans to keep reminding families that health should always be paramount, especially if their loved one has a special need.

There have been some changes to the healthcare system since the start of the pandemic. Even without a single COVID case, the healthcare network continues to meet frequently to discuss preparations for once a COVID case is present in the territory. The government is heavily involved in these conversations, and have implemented a Task Force that will have oversight and jurisdiction on all COVID operations, to even manage federal funds that pour in to address pandemic preparedness. Since the start of the pandemic, the LBJ hospital has received federal funding to improve infrastructure as well as equipment needed during an actual COVID spread on the island. The local health department received funding to also address the same needs, but also have built quarantine housing that would be used during repatriation efforts for local residents who were stranded off island.

Due to promotion of testing and vaccination for COVID, most of the healthcare workforce from DOH, LBJ, and the VA Clinic have been recruited to work these large community efforts, which in turn have caused some clinics to shut down for a time period. This has forced community members to delay seeking healthcare services in a timely manner. The Medicaid office has since been financing planes once a month from Hawaii to retrieve patients and their caretakers who are in need of critical care that are not available on island.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

All US Citizens and US National (born in American Samoa) are covered under the Title XIX Medicaid Program. Services provided by CHCs and the LBJ Medical Center receive Medicaid reimbursement. All children and pregnant women, regardless of birth place, are covered under Medicaid as well. Permanent residents and those with different immigration status will be covered by Medicaid only on emergency conditions. Regardless of this coverage, the local hospital continues to impose an "access" fee on people who access care from their services. Most people are required to pay either a $10 or $20 fee for medication or access a specific service such as ENT or the Eye clinic. Those exempted from this payment are usually those with military or private insurance which is a small percentage of the population that seeks care from the local hospital.

In discussions with Title XIX Medicaid staff, MCH inquired about children with special needs and their durable medical equipment (DMS) needs, the Medicaid staff explained that without local match from the American Samoa Government, Medicaid will not be able to provide coverage for DME requests. There is much effort needed to gather families and consumers to advocate to lawmakers and government leaders to mandate local matching so these necessary equipment and devices are afforded to support the independence of children with special healthcare needs. MCH will continue to look into ways to enable Medicaid funds to be used towards the lives of our children with special needs and their families.

Title V and Title IX's most recent meeting was on September 11, 2020. Dr. Anaise Uso, RHD Program Manager Ipu Eliapo and Matilda Kruse, the Medicaid Program Integrity Manager. According to Medicaid, they will continue to work with CHCs and MCH on efforts to increase coverage for MCH populations and ensure quality care across the healthcare system in AS. Agreements on periodical stakeholder meetings, at least twice a year, between Title V and Title XIX to continue this partnership and understanding between these two programs to benefit the MCH population altogether.

Medicaid Partnership as stated in the agreement (Figure 1), MCH shall monitor, assess and fund in part, MCH programs which provide public health service including care coordination to pregnant women, infants, children and adolescent including children and youth with special health care needs CYSHCN while Medicaid will reimburse the primary health care services.

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

Introduction to American Samoa's State Action Plan 2021-2025

The ASMCH Title V State Action Plan was developed through strategic planning and collective data reporting from the previous 5 years of healthcare services for women and children in American Samoa. This State Action Plan is a product of the coming together of local agencies, non-profit organizations, family representatives, legislators, and community leaders to place emphasis on issues that impact the health and wellness of Title V populations.

This State Action Plan details strategies developed by this group to target goals that are vital to improving the health and wellbeing of women and children in the territory. As time progresses and situations change, such as with the COVID pandemic, there is opportunity in the State Action Plan to make necessary adjustments to complement these changes but still reach established goals to some degree. Ultimately, the purpose for this action plan is to maintain a continuity of improvements to the healthcare system that cares for women, infants, children & adolescents, including children and youth with special healthcare needs.

Due to the territorial-wide COVID response efforts, some pieces of the State Action Plan have been modified to fit with the changes that are now becoming a norm for our community. Changes such as the availability of providers and clinic schedules on when they are open and able to provide services, as well as what type of services are available for the public.

Although there are measures in place that all states and territories must consider as common grounds to address similar issues for Title V populations, our State Action Plan includes priorities that are unique to the children of American Samoa, such as addressing Rheumatic Heart Disease. This capacity furthermore amplifies how important each jurisdiction should not hesitate to address issues that are exclusive to their own people, culture, and context.

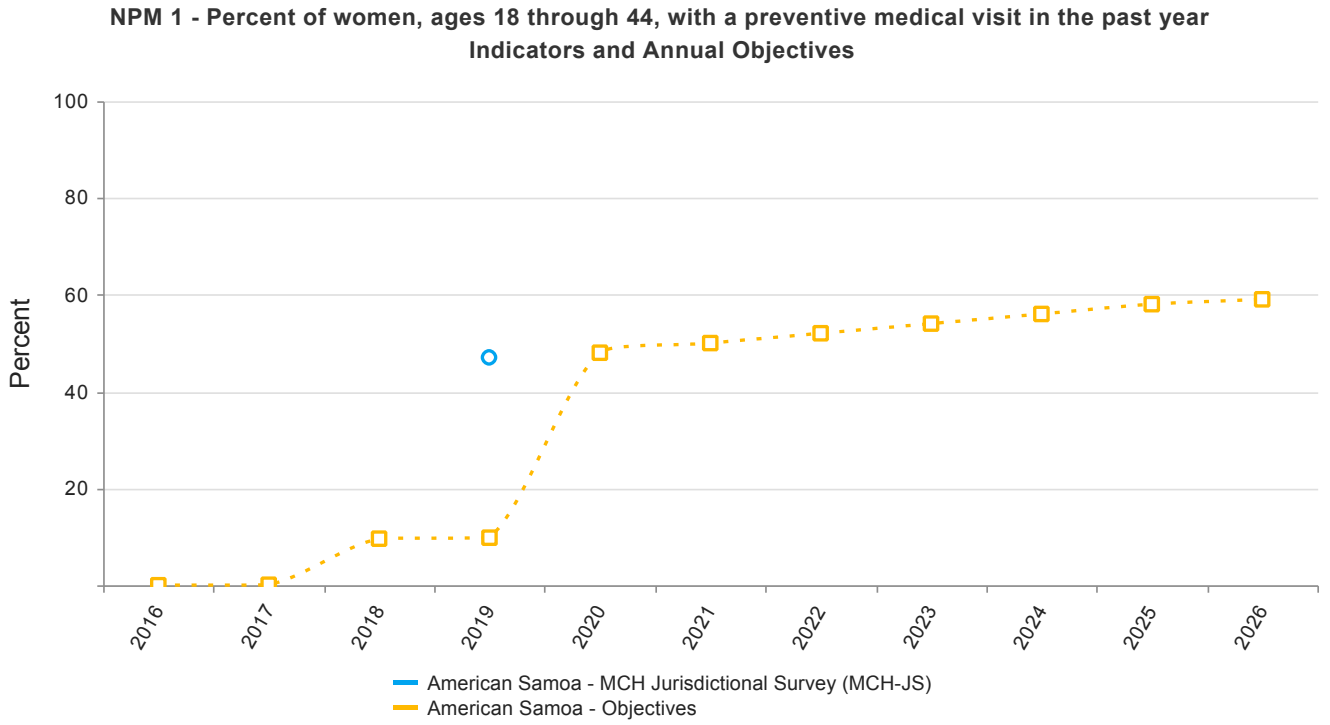
The following layout will emphasize on selected priorities for the next 5 years as detailed in the State Action Plan for American Samoa.

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	MCH-JS-2019	5.6 %	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	5.2 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	MCH-JS-2019	11.7 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	Data Not Available or Not Reportable	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	12.3	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	38.4	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	MCH-JS	Data Not Available or Not Reportable	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		48
Annual Indicator	47.0	47.0
Numerator	5,703	5,703
Denominator	12,140	12,140
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	0.1	0.2	9.7	9.9	48
Annual Indicator	9.4	9.5	27.5	35.4	27.7
Numerator	918	921	2,633	3,241	2,450
Denominator	9,720	9,720	9,561	9,147	8,847
Data Source	Postpartum Data	Postpartum Data	CHC UDS Report, US Census International Database	CHC UDS Report	CHC UDS Report
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	54.0	56.0	58.0	59.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of media outlets utilized to promote preventive medical visits.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			50	60	75.5
Annual Indicator	30	40	50	60	70
Numerator	3	4	5	6	7
Denominator	10	10	10	10	10
Data Source	DOH Media	DOH Media	DOH MCH Media	DOH MCH Media	DOH MCH Media
Data Source Year	2016	2016	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	76.0	77.0	78.0	79.0	80.0	81.0

ESM 1.2 - Percent of Providers receiving Technical Assistance Training in Prenatal Care Standards of Care and Provider Competencies.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	10	10
Data Source	CHC	CHC
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	40.0	60.0	80.0	90.0	90.0

ESM 1.3 - Percent of postpartum women, who received a depression screening after delivery.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	836	735
Data Source	CHC UDS	CHC UDS
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	50.0

ESM 1.4 - Percent of pregnant women who receive at least one preventive dental service in the past year.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	1.4
Numerator	10
Denominator	725
Data Source	FQHC UDS
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	1.4	5.0	10.0	15.0	20.0

ESM 1.5 - Percentage of women who have completed recommended COVID-19 vaccination doses .

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0.5
Numerator	45
Denominator	8,847
Data Source	ASIP WEBIZ
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	80.0	81.0	82.0	83.0	84.0

State Action Plan Table

State Action Plan Table (American Samoa) - Women/Maternal Health - Entry 1
Priority Need
Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
NPM
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Objectives
Increase percentage of pregnant women beginning prenatal care at first trimester by 2% every year, from 35.9% in 2019 to 45% in 2021
Strategies
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.

ESMs	Status
ESM 1.1 - Percent of media outlets utilized to promote preventive medical visits.	Active
ESM 1.2 - Percent of Providers receiving Technical Assistance Training in Prenatal Care Standards of Care and Provider Competencies.	Active
ESM 1.3 - Percent of postpartum women, who received a depression screening after delivery.	Active
ESM 1.4 - Percent of pregnant women who receive at least one preventive dental service in the past year.	Active
ESM 1.5 - Percentage of women who have completed recommended COVID-19 vaccination doses .	Active

NOMs

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 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

NPM: Well-Woman Visit

Priority: Early Prenatal Care - Annual Report

Last Year's (2020) Accomplishment:

1. The Maternal and Child Health (MCH) programs supported efforts to educate women about taking care of their health during pregnancy since the COVID pandemic began. Women were thoroughly informed in order to make confident decisions regarding their health in relation to COVID vaccinations and other related health matters.
2. The MCH Title V program continues to support efforts to build partnerships amongst nonprofit organizations and DOH programs. These partnerships are strengthened through meetings to discuss areas of the healthcare system that need much improvement, specifically in terms of serving pregnant women that may be dealing with social, financial, etc. issues. While discussions of how to improve healthcare services for women are crucial, these different programs and organizations also take into consideration the vital part they play in delivering the best healthcare services for women.
3. Title V Health Educators in the clinics informed women, who were walking in to receive monthly check ups about other services such as early prevention screenings. The importance of preventive screening is crucial for women that have a family history of cancer, as well as those who have health issues before and after pregnancy.
4. Title V Health Educators assisted in the HIV and STD programs educational services within the clinics. Emphasizing on the importance of using protection if a woman is having sexual relations with multiple partners and getting tested often for STD or HIV, to ensure a healthy reproductive system. It's very important for women to understand the impacts STD or infections can have on one's baby during pregnancy.
5. Title V Health Educators provided health education on Nutrition, the pathophysiology of conditions and preventative measures, care, and treatment for abnormal findings such as Hypertension, Diabetes, and Tuberculosis for all women accessing care through the LBJ Hospital or through the Health Centers.
6. Title V staff provided breastfeeding education before discharge of the maternal mothers in the Maternity Ward at LBJ Hospital. Consultation and health materials were made available to promote breastfeeding, proper nutrition, proper preparation for formula feeding, and the significance of consistently keeping up with immunization shots.
7. Title V staff conducted reminder calls to ensure that women showed up for their prenatal appointments at the clinics.
8. Title V staff continue to retrieve Postpartum/Newborn cards and CSN referrals from the Nursery and Maternity Wards. The dataset is then stored into the SILAS database. The demographic information retrieved from the Postpartum/Newborn cards include:
    a. Prenatal visits (gestational age at the first prenatal visit and the number of visits throughout the pregnancy upon giving birth, date of delivery and discharge); Gravida and Para notation; postpartum date of appointment; and Hemoglobin status before discharge.
    b. Newborn, gestational age at birth; birth weight, height, head circumference; complications at birth; and appointment for their first well visit and immunization.
    c. Cross-check information in the EHR system.
9. The DOH spearheaded efforts to protect American Samoa from the COVID-19 pandemic. This required all DOH staff to contribute in manning vaccination sites, supporting quarantine efforts, and organizing vaccination

outreaches. During this time, the Title V staff was able to schedule eligible women for vaccination and made sure they were referred to the necessary doctors to answer any of their questions.

Challenges:

1. Shortage of clinicians to administer services to pregnant women within the territory.
2. The current healthcare system does not provide pregnant women with quality healthcare in terms of customer service. This is a blocking agent that hinders some women from showing up to their appointments.
3. Demands to prioritize utilization of staff for COVID-19 efforts for extensive periods of time. This takes away from providing the quality care that pregnant women need during this crucial time in their lives.
4. DOH clinics closed early and often throughout 2020 due to COVID-19 restrictions and procedures. All of the healthcare workers in DOH had to report to vaccination sites, closing clinics situated in rural areas. This made it inconvenient for women in those areas to access reliable healthcare.
5. Due to COVID-19 restrictions, pregnant women were referred to the OBGYN clinic at the hospital. DOH clinics were incapable of serving them during the beginning of the COVID-19 pandemic.

Current Activities (2020):

1. COVID-19 prevention support efforts across the territory (vaccinations and testing)
2. Breastfeeding and Nutrition promotion at the LBJ Hospital
3. Continue to provide health education to all women attending Tafuna Health Center for prenatal or non- prenatal care.
4. Retrieve Postpartum/Newborn Cards from Nursery and Maternity; enter data in the SILAS database.
5. Collaboration with the Department of Social Services, LBJ Hospital and nonprofit organizations to support services catered to women in the territory.

Plan for Upcoming Year (2021):

OBJECTIVE 1.1: By 2024, increase the percentage of pregnant women accessing early prenatal care at first trimester by 2% every year for the next five years (40.2% in 2019 to 45.4% in 2024).

In 2020, the percentage of women accessing prenatal care at the first trimester decreased by almost 2% from 40.2% to 38.7%. This was expected given the numerous changes in healthcare services since the start of the pandemic. It is obvious that the percentage of pregnant women seeking initial care at the first trimester declined due to these changes. Also, because clinics were closed so that the workforce could administer COVID vaccinations in large settings or those providers were not present or available to deliver the service; women were not receiving this important service.

Strategies:

1. Collaborate with all Prenatal Providers and supporting programs (BCCP, MEICHV, NCD, Intersection Inc., WIC) to promote early prenatal care services through utilization of the curriculum ***STRONG***.
2. Provide public service announcements such as videos and mass media campaigns to encourage pregnant women to seek early prenatal care.
3. Ensure all health education materials and resources for selected curriculums are translated appropriately and standardized across all prenatal clinics.
4. Provide & support online training for providers on quality care for pregnant women.
5. Collect feedback and recommendations from pregnant women on ways to improve services for prenatal care.

ESM: 1.1: Promote Early Prenatal Care at the First Trimester of Pregnancy

Most of these strategies were put on hold as emphasis was on COVID prevention and continues on to the present day.

NPM: Well-Woman Visit
Priority: Women's Health Visit

Plan:

OBJECTIVE 1.2: 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 (35.4% in 2019 to 44.1% in 2024).

In 2020, the percentage of women with a preventive medical visit decreased by almost 2% from 35.4% to 27.7%. This was expected given the numerous changes in healthcare services since the start of the COVID-19 pandemic. It is obvious that the percentage of women seeking preventive care visits was also at a decline due to the changes brought forth by the response of our local government towards COVID-19. Clinics were often closed and providers were stranded elsewhere, leaving services for women at a bare minimum.

Strategies:

1. Provide mass media campaigns to promote preventive medical visits for all women in child bearing ages.
2. 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).
3. Formulate and disseminate a women's check-up passport to improve tracking and monitoring of age-appropriate visits and screening appointments.
4. Provide & Support online training for providers on quality care for non-pregnant women.
5. Collect feedback and recommendations from all women on ways to improve services for care.

ESM: 1.1: Promote Preventive Medical Visits for Women Ages 18-44.

Most of these strategies were put on hold as emphasis was on COVID prevention and continues on to the present day.

Perinatal/Infant Health

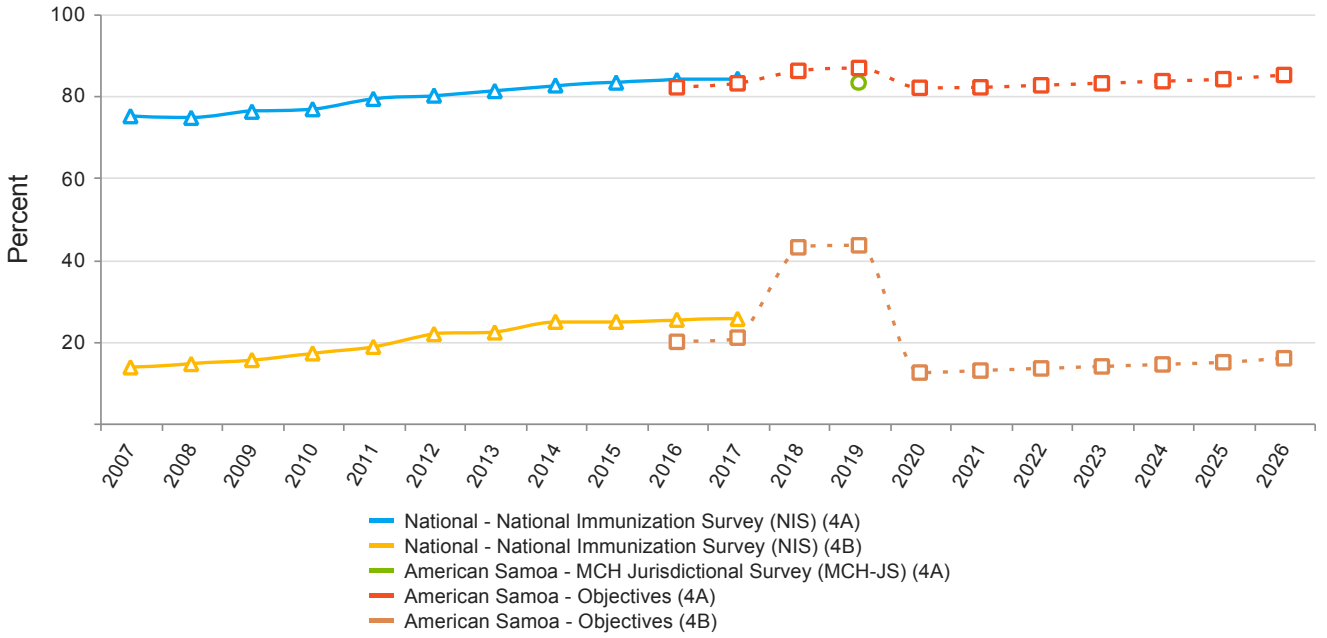
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	12.3	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 4
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 4

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	86.7	81.9
Annual Indicator	83.0	83.0
Numerator	6,253	6,253
Denominator	7,533	7,533
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	82	83	86	86.7	81.9
Annual Indicator	76	75.1	72	81	79.8
Numerator	753	701	630	665	580
Denominator	991	934	875	821	727
Data Source	ASWIC	ASWIC	ASWIC	ASWIC	ASWIC
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	82.0	82.5	83.0	83.5	84.0	85.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	20	21	43	43.5	12.5
Annual Indicator	9	8	13	12.1	8.1
Numerator	89	75	114	99	59
Denominator	991	934	875	821	727
Data Source	ASWIC	ASWIC	ASWIC	ASWIC	ASWIC
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.0	13.5	14.0	14.5	15.0	16.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of mothers initiated breastfeeding of their infants within 1 hour of birth.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	56.6
Numerator	415
Denominator	733
Data Source	SILAS
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	60.0	65.0	70.0	75.0	80.0

ESM 4.2 - Percentage of providers and health educators receiving breastfeeding TA training.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	10
Data Source	FQHC UDS REPORT
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	30.0	40.0	50.0	60.0

ESM 4.3 - Percentage of BF women who access the virtual chat room for lactation and peer counseling.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	838	725
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.4	3.0	5.0	10.0	20.0	30.0

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

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	1.4
Numerator	10
Denominator	733
Data Source	MCH TITLE V
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	5.0	10.0	20.0	30.0

ESM 4.5 - Percentage of Breastfeeding Feeding Coalition Members who report they meet at least 6 times a year

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	10
Data Source	MCH TITLE V
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0

ESM 4.6 - Percent of House and Senate who are aware of the importance of paid Maternity Leave.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	6.7
Numerator	0	2
Denominator	30	30
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	50.0	60.0	70.0	80.0	90.0

State Performance Measures

SPM 1 - Percent of newborns receiving Blood Spot Screening

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	733
Data Source	SILAS
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	10.0	15.0	20.0

State Action Plan Table

State Action Plan Table (American Samoa) - Perinatal/Infant Health - Entry 1

Priority Need

Families are empowered to make educated choices about infant health and well-being.

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

Increase percentage of breastfeeding mothers by 5% in 2024.

Increase by 5%, 6 months infants who exclusively breastfeed in 2024.

By 2024, 50% of postpartum women are eligible for paid maternity leave.

Strategies

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.

Introduce a bill and budget to legislatures for approval to mandate all government agencies provide paid maternity leave.

ESMs	Status
ESM 4.1 - Percent of mothers initiated breastfeeding of their infants within 1 hour of birth.	Active
ESM 4.2 - Percentage of providers and health educators receiving breastfeeding TA training.	Active
ESM 4.3 - Percentage of BF women who access the virtual chat room for lactation and peer counseling.	Active
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	Active
ESM 4.5 - Percentage of Breastfeeding Feeding Coalition Members who report they meet at least 6 times a year	Active
ESM 4.6 - Percent of House and Senate who are aware of the importance of paid Maternity Leave.	Active

NOMs
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

State Action Plan Table (American Samoa) - Perinatal/Infant Health - Entry 2

Priority Need

Establish a Newborn Metabolic Screening Program in American Samoa

SPM

SPM 1 - Percent of newborns receiving Blood Spot Screening

Objectives

By November 2021, Technical Assistance request is formally sent to American Samoa Title V Project Officer at MCHB and AMCHP Regional IX Representative to establish guidelines, timeline and activities for the next five years for implementing a Blood Spot Screening program.

By June 2022, 80% of the House Representative and Senate members understand and approve the BSS bill and budget.

By June 2023, 50% of medical providers and laboratory staff will be trained in BSS Standard Operating Procedures.

By June 2024, at least 25% of newborns receive a Blood Spot Screening and refer for treatment.

Strategies

Request Technical Assistance consultant to MCHB and AMCHP to initiate American Samoa Blood Spot Screening (BSS).

Establish a timeline of necessary contacts locally and internationally that will play a role in going live with the BSS Program.

Introduce the bill and budget to legislatures to mandate the BSS Program at LBJ Hospital.

Ensure all newborns receive BSS by year 2025.

State Action Plan Table (American Samoa) - Perinatal/Infant Health - Entry 3

Priority Need

Establish a Newborn Metabolic Screening Program in American Samoa

Objectives

By November 2021, Technical Assistance request is formally sent to American Samoa Title V Project Officer at MCHB and AMCHP Regional IX Representative to establish guidelines, timeline and activities for the next five years for implementing a Blood Spot Screening program.

By June 2022, 80% of the House Representative and Senate members understand and approve the BSS bill and budget.

By June 2023, 50% of medical providers and laboratory staff will be trained in BSS Standard Operating Procedures.

By June 2024, at least 25% of newborns receive a Blood Spot Screening and refer for treatment.

Strategies

Request TA to MCHB and AMCHP to initiate American Samoa Blood Spot Screening (BSS).

Establish a timeline of necessary contacts locally and internationally that will play a role in going live with the BSS Program.

Introduce the bill and budget to legislatures to mandate the BSS Program at LBJ Hospital.

Ensure all newborns receive BSS by year 2025.

Last Year (2020) Accomplishments

4a. Percent of Infants who are ever breastfed					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Indicator	80.9	79.8			
Numerator	675	**580**			
Denominator	834	727			
Data Source	AS WIC				
4b. The percent of infants breastfed exclusively through 6 months					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Indicator	12.1	8.0			
Numerator	99	**58**			
Denominator	821	727			
Data Source	AS WIC				

- Continued promoting good healthy eating and importance of early prenatal care through Health Education sessions with women at their initial visit for Prenatal Care. These education sessions are done at Leone, Amouli and Tafuna Health Center.

- Continued partnership efforts with the DHSS WIC program to provide informational sessions, including the importance of early consistent prenatal care, and child spacing with family planning available methods to women who access services at their sites.

- Advising the women through outreach to register early for prenatal care, so they can be qualified with the prenatal care package provided by LBJ for women who seek care during the first trimester of pregnancy.

The American Samoa Government continues to uphold the breastfeeding executive order which offers employees who are newly lactating mothers (up to 6 months after delivery) two hours of breastfeeding away from work, daily. Mothers were allowed to either break off during the day depending on their schedules approved by their supervisors to either pump and store their milk, or deliver them to wherever their infants were cared for during their time at work (home, daycare etc.).

MCH Health Educators, Conference Alailefaleula and Manulelei Silva-Aitaoto, continually promote breastfeeding before, during, and after delivery at clinical settings. They both provide health education in various venues weekly; CHC Prenatal Clinics, Well Baby Clinics and the LBJ OBGYN clinic and ward.

At the LBJ Hospital labor and delivery room, mothers are with their babies administering continuous skin-to-skin contact immediately after birth and until the completion of the first feeding. The delay in skin-to-skin contact is interrupted or not given if there is a medically justifiable reason. Routine procedures (e.g., assessments, Apgar scores, etc.) are done with the baby skin to skin with the mother. Procedures requiring separation of the mother and baby (bathing, for example) are delayed until after this initial period of skin-to-skin contact, and should be conducted, whenever feasible, at the mother's bedside. MCH Health Educators are present to encourage new mothers while inpatient to continue breastfeeding efforts.

Additionally, skin-to-skin contact is encouraged throughout the hospital stay. The nursery staff and OBGYN ward staff promotes babies rooming in with their mothers unless other tests are needed to be done or babies need more attention (NICU babies) or mothers are not able to room in with baby due to medical reasons. When discharged, postpartum moms are encouraged to continue to breastfeed and are given instructions and phone numbers to call if they need assistance.

American Samoa WIC continues to promote peer to peer counseling, provide a 24-hour hotline as well as home-visits when requested by lactating mothers for hands-on demonstration and assistant. There are four different WIC sites through-out Tutuila and one each in Ta'u and Ofu (Manu'a Islands). Breastfeeding coalition members (MCH, LBJ Nursery, WIC, Nursing, CHC, OBGYN, MIECHV, STRONG) align and strengthen infant feeding education and continues to support and promote exclusive breastfeeding to women before, during and after pregnancy.

Throughout 2020, most of the work by the overall DOH staff was done in response to COVID operations, therefore drawing manpower, time, and resources away from program plans that were already in place. This challenge has been ongoing and it is valid to the present time. However, we will continue to make adjustments to ensure we progress on in improving the lives of women and infants in our communities.

Strengths

- Breastfeeding Coalition includes ASMCH, WIC, LBJ Nursery and Pediatricians, OBGYN and Labor and Delivery Staff, Consumers and Legislatures.
- Breastfeeding peer-to-peer counselors are available at WIC centers
- LBJ hospital implementing more than half of the guidelines for a Baby Friendly hospital including babies rooming in with their mothers, skin-to-skin contact first hour of life and more, breastfeeding room for hospital staff to pump and store breast milk.

Challenges

- LBJ Hospital and Public Health will need to be the leaders in enforcing "Baby Friendly" regulations to promote breastfeeding of newborns. Formulas are still seen at nursery being fed to babies if mother consents to it even if they can breastfeed or not. There are no assigned spaces for new mothers to breastfeed once they return to work in public health settings.
- Breastfeeding Coalition has been inactive for several years now due to conflict of schedules of members, as well as difference in priorities.
- The measles island wide vaccinations and COVID-19 operations limited efforts to provide outreach activities in the community and workplaces as planned due to staff meeting other needs of the department.
- Waiting time in the clinics discourages mothers to see the doctor during their appointment

Perinatal/Infant Health - Application Year

Current Activities (2021)

- Collaboration efforts with various partners such as Aiga Manuia MIECHV Program, CHC Prenatal Clinics, OBGYN, and WIC are continually strengthened to promote early prenatal care, breastfeeding, depression screenings, and well child visits for the first 12 months of life. These combined efforts warrant larger populations reached for pregnant women and infants rather than working individually.
- The responsibility of the ASMCH health educators is to provide prenatal care education to promote exclusive breastfeeding for mothers, alongside the American Samoa WIC Breastfeeding Peer Counselors. The ASMCH educators in the clinic help with the distribution of standardized breastfeeding resources available in Prenatal Clinics, OBGYN Clinic, and the WIC office to encourage and provide support for all mothers who breastfeed.
- Due to the COVID-19 pandemic, the ASMCH staff continue to provide support and care coordination over the phone and on social media by sending out messages specifically catering to MCH populations.
- The ASMCH program continues to provide staff support for the local immunization program. The ASMCH staff contribute in updating age-appropriate immunizations for all children from 0-18 years of age. They also deliver reminder calls and assist with updating the WEBIZ database. The ASMCH's staff efforts ensure all infants and children are protected from preventable childhood diseases.
- The ASMCH staff assist in registration and processing of incoming patients on a daily basis within the clinics, as well as during community outreaches for vaccinations. The process for prenatal care available for women begins with a pregnancy test. Once the test result comes back positive, the interviewing process begins by registering the patient in the EHR system. Once registration is complete, the patient will receive an appointment to return for their initial prenatal appointment. The ASMCH Health Educators provide individual counseling on balanced nutrition, healthy eating habits, breastfeeding benefits, and many other health issues that may occur during pregnancy. These pregnant women are also advised to consider taking prenatal iron tablets and oral vitamins to assist their bodies during this time period; emphasizing the importance of early and consistent prenatal care. Patients with negative pregnancy test results are advised to recheck in two weeks and are referred to a specific provider for further care.
- The ASMCH Health Educators provide sessions and counseling twice a week to promote healthy behaviors during pregnancy that are likely to lead to positive outcomes. The health education session offered is conducted in both group and individual settings, depending on the needs of the pregnant women. Topics typically covered during these educational sessions include but are not limited to breastfeeding benefits for mother and baby, common discomforts, comfort measures, family planning, personal goals, baby care and safety, oral health, etc.
- At each prenatal visit, body mass index (BMI) and blood pressure of all pregnant women are consistently monitored throughout the 9-month period. Assessment of fetal heart tones and fundal heights are also done by providers at every visit.
- Covering quarantine sites locally and neighboring islands for COVID-19 operations.
- Continue initial planning phase meetings with identified consultant for establishing American Samoa's Blood Spot Screening program for newborns.

Future Plans (2022)

- Lead efforts to establish and mandate a Blood Spot Screening Program for all newborns in the territory.
- Provide educational forums for the community, legislators, and health leaders on the importance of establishing a territorial Blood Spot screening program to save newborn babies.
- Continue to advocate for developmental screenings in well child clinics to detect developmental delays in infants and children in the first 3 years of life.
- Provide continuous support to providers through training and evidence-based curriculum from MCH Evidence website
- Promote the utilization of the 2-hour lactation policy for ASG employees as well as for the private sector, promoting exclusive breastfeeding for working mothers during the infant stage.
- Promote paid maternity leave for working mothers after giving birth for up to 6 months. Educate lawmakers on the benefits of a healthy mother, healthy child as shown in other countries who already have these measures in place.
- Continue to conduct data sharing with program partners in reference to women and infant health.
- Lead efforts to implement a support system to screen women who experience postpartum depression, fetal demise, or stillbirth and have not returned for a postpartum check up.
- Continue to promote awareness on psychological conditions that may impact the overall health of a new mother and infant if they are not properly assessed and cared for.
- Encourage private and governmental sectors to spearhead a designated area (lactation room) at the workplace, for mom to breastfeed or pump breast milk.
- Encourage parents to use WIC food packages as only supplements for proper nutrition for pregnant women, infants & children.
- Continue utilizing Telehealth care systems installed in clinics to ensure services are still provided to patients despite restrictions due to the COVID-19 pandemic.

Child Health

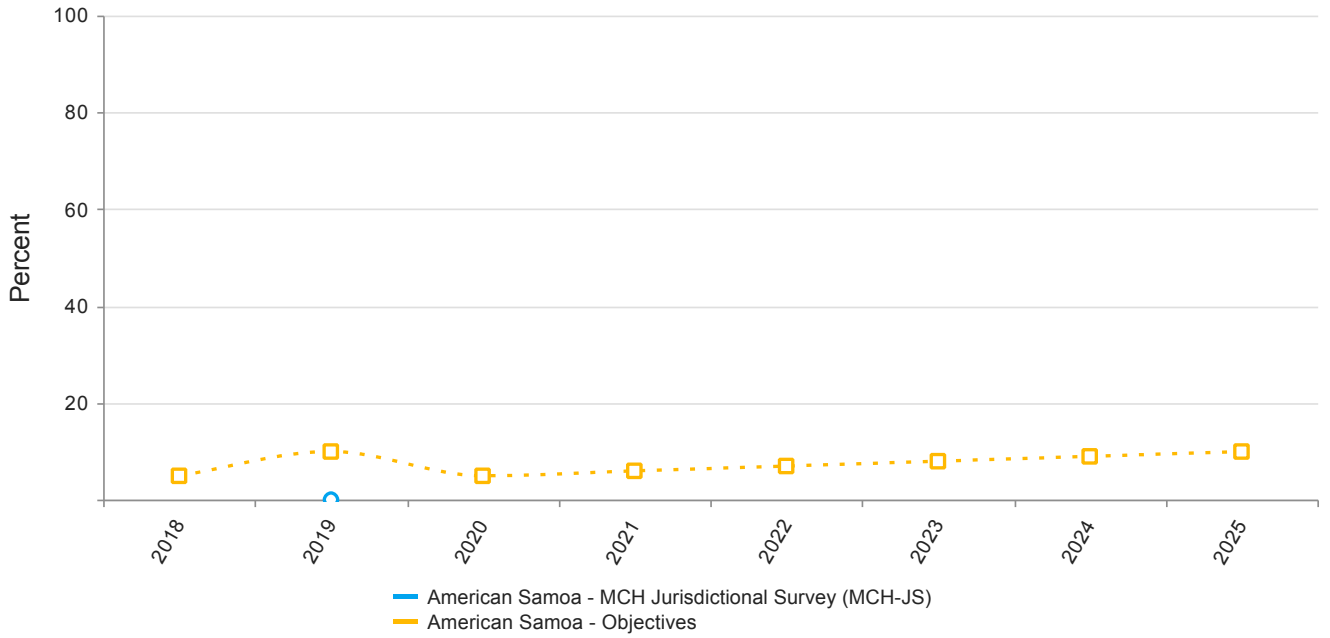
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	MCH-JS-2019	11.8 %	NPM 13.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	0 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	69.6 %	NPM 6 NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 6 NPM 13.2

National Performance Measures

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

Indicators and Annual Objectives



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	10	5
Annual Indicator	0	0
Numerator	0	0
Denominator	2,859	2,859
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			5	10	5
Annual Indicator	2.9	3	1.3	5.3	7.1
Numerator	180	180	49	197	352
Denominator	6,256	6,028	3,861	3,724	4,939
Data Source	Part c and MEICHV	Part c and MEICHV	MCH CSHCN and Part C Helping Hands Early Intv.	MCH CSHCN and Part C Helping Hands Early Intv.	MCH CSHCN and Part C Helping Hands Early Intv.
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	7.0	8.0	9.0	10.0	11.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Percent of providers serving children and families participating in learning collaborative.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	20	20
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

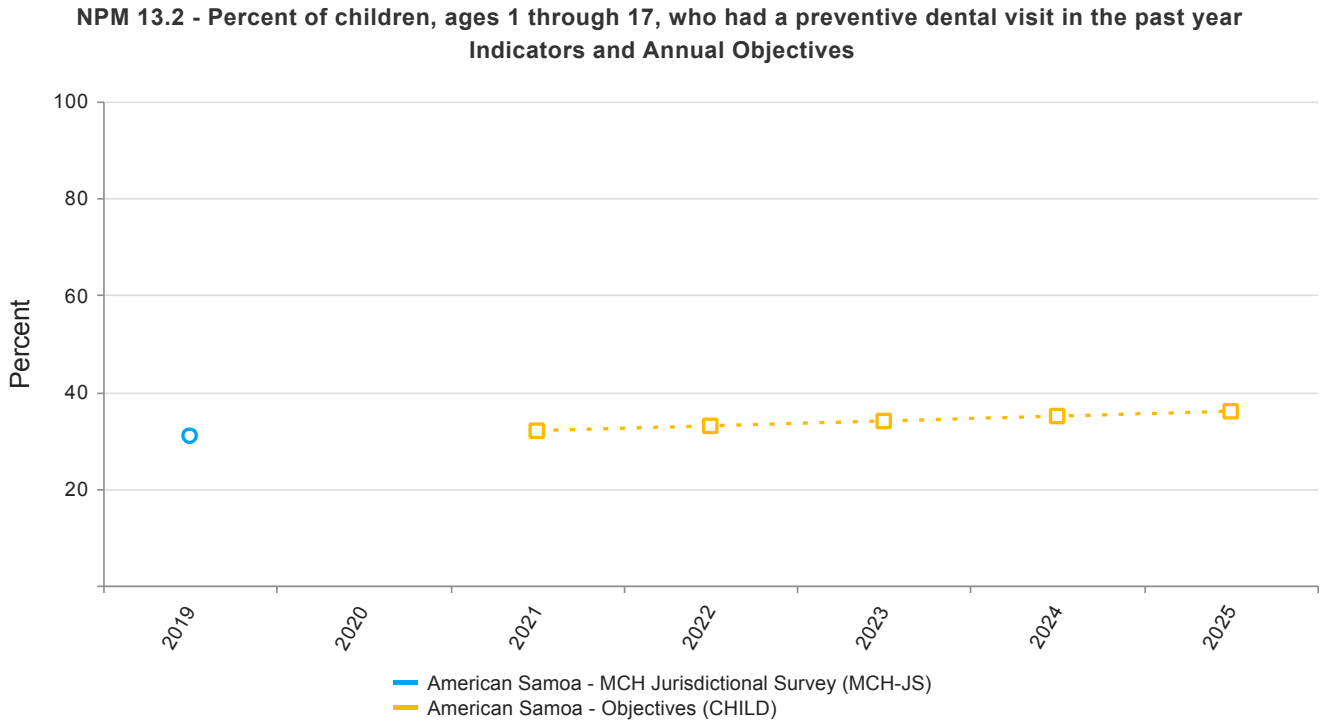
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	60.0	70.0	80.0	90.0	95.0

ESM 6.2 - Percent of families who participated in community outreach activities hosted by MCH to promote developmental screenings.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	2.1	2.5
Numerator	57	60
Denominator	2,721	2,427
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	12.0	14.0	16.0	18.0	20.0



NPM 13.2 - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		
Annual Indicator	31.1	31.1
Numerator	6,934	6,934
Denominator	22,263	22,263
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	43.6	4.7
Numerator	6,934	687
Denominator	15,918	14,546
Data Source	MCH Jurisdictional Survey	CHC UDS Report
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.0	33.0	34.0	35.0	36.0	37.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percent of children 0-3 years receiving fluoride varnish at least twice a year.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	3.2	2.2
Numerator	90	53
Denominator	2,807	2,427
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	5.0	10.0	20.0	30.0	30.0

State Performance Measures

SPM 2 - Percent of children ages 3 who have completed their age-appropriate routine vaccinations.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		4	51	51.2	51.5
Annual Indicator	51.3	40.1	42.5	40.5	32.8
Numerator	1,144	1,130	1,139	1,070	2,640
Denominator	2,230	2,820	2,680	2,643	8,049
Data Source	AS IP	ASIP	ASIP	ASIP	ASIP
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	52.0	53.0	54.0	65.0	65.0	66.0

SPM 3 - Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			29	30	31
Annual Indicator	34.8	43.6	15.1	9.4	0
Numerator	49	60	20	12	0
Denominator	14,071	13,749	13,248	12,768	11,286
Data Source	RHD registry 2016	RHD registry	MCH RHD Registry (BYU, OSHU, MCH)	MCH RHD Registry (BYU, OSHU, MCH)	MCH RHD Registry
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.0	31.0	30.0	14.1	12.0	0.0

State Action Plan Table

State Action Plan Table (American Samoa) - Child Health - Entry 1
Priority Need
Developmentally appropriate care and services are available for all children.
NPM
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
Objectives
By December 2021, two meetings will be initiated to establish an interagency committee on Developmental Screenings.
By March 30, 2021, 75% of CHC Providers will complete a refresher CME session on Developmental Screenings for Children ages 0-3 years.
By September 30, 2021, MCH Program Staff will complete 4 outreach activities targeting families and communities regarding developmental screening.
By March 30, 2021, 50% of CHC providers will report the've received CME presentations on BMI screening, behavioral counseling and referral and are confident to provide such services.
Strategies
Promote developmental screening rates.
Promote BMI documentations and weight management of children ages 0-5 years.

ESMs	Status
ESM 6.1 - Percent of providers serving children and families participating in learning collaborative.	Active
ESM 6.2 - Percent of families who participated in community outreach activities hosted by MCH to promote developmental screenings.	Active

NOMs
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

State Action Plan Table (American Samoa) - Child Health - Entry 2

Priority Need

Developmentally appropriate care and services are available for all children.

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By September 2021, increase the percentage of children 0-3 years receiving at least two topical fluoride varnish treatment and oral hygiene instructions.

Strategies

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.

ESMs	Status
ESM 13.2.1 - Percent of children 0-3 years receiving fluoride varnish at least twice a year.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (American Samoa) - Child Health - Entry 3

Priority Need

Developmentally appropriate care and services are available for all children.

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By September 2023, increase the percentage of children 0-3 years receiving at least two topical fluoride varnish treatment and oral hygiene instructions.

Strategies

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.

ESMs	Status
ESM 13.2.1 - Percent of children 0-3 years receiving fluoride varnish at least twice a year.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (American Samoa) - Child Health - Entry 4

Priority Need

Developmentally appropriate care and services are available for all children.

SPM

SPM 2 - Percent of children ages 3 who have completed their age-appropriate routine vaccinations.

Objectives

By July 2021, increase immunization coverage of children ages 35 months who receive up to date routine vaccinations by 2%.

Strategies

Partner with the Immunization Program to produce two Public Service Announcements and advertise on local media outlets and social media.

State Action Plan Table (American Samoa) - Child Health - Entry 5

Priority Need

Reduce Rates of Rheumatic Heart Disease

SPM

SPM 3 - Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.

Objectives

Increase by 2% the percentage of children ages 4 - 17 years of age who attends 90% of their appointed Bicillin shots annually, by September 30, 2020.

Strategies

Continue to provide call reminders 1 week, then 1 day prior to to appointment date.

Continue to provide mass media campaign in promoting RHD Clinic.

Establish RHD clinics at Leone and Amouli Health Centers.

Offer pick up and drop off at appointments.

Provide Care Coordination for children diagnosed with RF and RHD and ensure they are compliant with their antibiotic prophylaxis every 21 days.

Enter encounters and Bicillin shots in SILAS for tracking and monitoring. This will generate the RHD registry.

2020 Accomplishments:

- ASMCH certified dental assistant working at CHC provided fluoride varnish to children at the well-baby clinics in Tafuna and Fagaalu. Children are provided also with incentives such as a toothbrush, floss and toothpaste and oral health pamphlet. Data shows from the UDS at CHC, the number of children ages 1-3 who receive dental preventive services decreased, from 1144 in 2019 to 54 in 2020. This drop in numbers are seen across all services and with different age groups due to the changes caused by COVID.

- MCH Title V continually works closely with the different divisions in the Department of Health: CHC clinics, Nursing Division, Immunization program, etc. to minimize and control the measles outbreak through immunization outreach that took place at the end of 2019 and into the beginning of 2020. The collaborative efforts of the MCH Title V and the different programs within DOH carried on throughout the year due to COVID-19.

- Intergovernmental agency partnerships were forged throughout this period of planning preventive measures, to implement within the healthcare system, as well as procedures for when a person with COVID-19 comes to the island.

- Media coverage increased to raise awareness and promote child services available at the different clinics throughout the year in preparation for a COVID case on island

- MCH Title V staff and clinicians utilized the Ages & Stages Questionnaire (ASQ) screening tool to identify children with developmental delays. Once a child is identified to have a developmental delay, MCH staff will make the necessary program referrals.

- Partnerships between MCH Title V and clients' medical home clinicians have strengthened, ensuring that these children are referred in a timely manner to receive preventive care through different programs in the healthcare system.

- Efforts to support the Bicillin Clinic at the Community Health Centers for all children with Rheumatic Heart Disease are continued. Staff emphasizes to participants of the program the importance of compliance and maintaining a healthy lifestyle to support heart health throughout their young lives.

Strengths

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.

Of the 209 children under the MCH Zika Program, 172 of these children received a developmental screening (ASQ) led by the MCH Zika staff. This is about 82% of this population, with .03% of which were identified with developmental delays and referred for early intervention services. This is an improvement from the year before, noting that developmental screenings are a crucial part of growth and should consistently be done throughout the first five years of life.

SPM 2 - Percent of children, ages 1 through 3 years, who had a preventive dental service in the past year.

- There are plenty of children this age group attending the Well Baby Clinics.
- MCH Dental Assistant provides care coordination, referrals and appointment reminders. She also assists with the oral health surveillance of this initiative.

SPM 3 - Percent of children ages 3 who have completed their age-appropriate routine vaccinations.

- The Immunization Program provides technical assistance for clinicians and nurses, providing vaccines as well as being responsible for updating the database WebIZ.
- MCH Epi provides surveillance and reporting to key leaders and stakeholders.
- Headstart ECE collaborates with DOH and enforces the completion of all required vaccines prior to entering preschool.

SPM 4 - Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.

- Ultrasound machines are available
- Trained personnel are available to provide limited RHD echocardiograms.
- Pediatric Cardiologists on a voluntary basis read these echos and send results back to the RHD coordinator.
- Antibiotic prophylaxis Bicillin is now affordable through the 340B program.

Challenges

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.

- Awaiting ASQ tools to be purchased.
- Clinicians may approve of the new screening tool but may not have time to provide the screening if it's lengthy.
- Once a tool is purchased, it may still need to be translated.

SPM 2 - Percent of children, ages 1 through 3 years, who had a preventive dental service in the past year.

- Inadequate space at the Tafuna dental clinic to accommodate four dentists at a time. There are only three dental chairs and barely any other space for a fourth dentist to utilize.
- COVID response efforts were and still are priority over all other health matters.
- Clinics were often closed for lengthy periods so the workforce can accommodate COVID operations.
- Shortage of staff from time to time due to burnout and being reassigned to other work sites.
- CHC purchasing of dental supplies takes a long time. MCH has been providing fluoride varnish and dental sealants in the last three years.

SPM 3 - Percent of children ages 3 who have completed their age-appropriate routine vaccinations.

- Families wait until the child is ready to be registered for preschool then bring their children to update their vaccinations. It may take more than one visit to complete them.

- Newly purchased fridges to keep vaccines are distributed throughout the health centers for utilization.

SPM 4 - Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.

- Need a full-time echo technician dedicated to RHD screening. Right now, trained personnel have other commitments and only screen when they are available.
- Need commitment from the advisory board to meet more frequently.
- Need to hire additional staffing to support RHD efforts.
- The measles outbreak resulted in school closures.
- Parents were afraid to take their children anywhere.
- Due to COVID-19 schools were closed and school was done virtually.
- Directed to help out with the measles and COVID-19 campaign put most of ASMCH priorities on the back burner for more than a year.
- Border closure caused delay in receiving supplies and materials.

Current activities for 2021

- Outreach programs to private and public schools are continued with ASDOH placing substantial emphasis on students being fully immunized prior to school entrance.
- The Nursing Division, Immunization Program, and MCH Title V continue to work collaboratively to address immunization concerns for the territory, particularly during potential outbreaks (such as measles) based on geographical surveillance. ASDOH leaders are consistently updated and well informed of such issues to provide guidance on best practices and approaches necessary to prevent local outbreaks and epidemics.
- Media coverage throughout the year on radio, newspaper, and local TV stations as well as social media to promote age-appropriate immunizations and well child services available at the health centers.
- Zika Navigators worked collaboratively with the Immunization staff to assist families who need to get updated vaccinations for their children by providing support in terms of transportation to and from well-baby clinics, re-appointments, and support for social issues that may hinder a child from receiving updated immunizations.
- Improve coordination of referral services between the client's medical home and the DOH programs that serve children, to include Helping Hands (early intervention), Helping Babies Hear, MIECHV, and Children with Special Health Care Needs.
- The Pediatrician at the Well-Baby Clinic informs parents the importance of oral hygiene when their child starts teething.
- The Pediatrician will send the child to the dental clinic for a check-up once she notices that the child has teeth.
- The Dental Clinic provides services to the child and informs the parent about oral hygiene for their child.
- MCH and the Tafuna Dental Clinic have a dentist and dental assistant that provides dental services to the schools that are located in Manu'a.

Future Plans 2022

- Plan & Implement training for providers at the well-baby clinics to utilize standardized screening tools to detect developmental delays among the children population so early detection and treatment or necessary services are provided at most appropriate times.
- Promote MCHAT screening tool to providers to screen children ages 0-3 for developmental delays that may suggest being on the spectrum disorder. Children can be found early on and can receive early intervention services.
- Promote referral of all children 1 year of age from CHC Well Child Clinics to dental clinics for their first dental visit
- Increase percentage of children ages 1-3 years receiving fluoride varnish at least twice a year.
- Continue to collaborate with the immunization program and promote school outreach activities.
- Title V and Immunization Program will collaborate to continue to provide Mass media campaigns for immunization compliance.
- MCH Client Navigators to assist with updating immunization shots in WEB IZ if data entry is behind.

- MCH Client Navigators will continue to provide care coordination services to all Title V & Zika clients (reminder calls, transportation, health education).
- Revive the RHD Prevention Advisory Board to provide support through program reviews, promote and support program activities, policies, resolutions and accountability.
- Continue to provide and support CME training needs for providers, health educators and partners.
- Collaborate with agency and community partners and families to implement heart health activities including RHD prevention leading up to World Heart Day on September 29.
- Build and maintain a comprehensive RHD registry database for all health entities to access and use in the territory.
- Revise the RHD Strategic Plan to include progress of systems of care for RHD clients.
- Provide care coordination for children to ensure compliance with bicillin shot appointments, including follow up and reminder calls.

Domain: Child Health

PRIORITY 4. Developmentally appropriate care and services are available for all children.

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 in 2020.

OBJECTIVE 6.1.1: By December 2021, there should be at least one selected screening tool utilized by well-baby providers to screen all children by the age of 35 months.

OBJECTIVE 6.1.2: By September 30, 2022, MCH will collaborate with Leo-o-Aiga Center (F2F) to implement 4 activities that will target developmental screening among young children.

OBJECTIVE 6.1.3: By March 30, 2021, 50% of CHC providers will report they've received CME presentations on BMI screening, behavioral screening, and will provide necessary referrals to the appropriate services.

Strategies:

1. Select evidence based developmental screening tools that are culturally appropriate, and population based to be utilized by health providers across the territory.
2. Promote and support utilization of screening tools for physicians and nurses at CHC.
3. Conduct quarterly evaluations on collected data to improve screening tools
4. Produce quarterly reports that will be used by the MCH team to discuss concerns and issues with clinical personnel at the CHCs
5. Promote BMI documentations and weight management of children ages 0-5 years.

ESMs

ESM 6.1.2 - Percent of providers serving children and families participating in learning collaborative.

ESM 6.1.3. - Percent of families participating in community outreach activities hosted by MCH to promote developmental screenings.

Domain: Child Health

PRIORITY 4. Developmentally appropriate care and services are available for all children.

NPM 13.2. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

- **promote preventive oral health services**

OBJECTIVE 13.2.1 By September 2023, increase the percentage of children 0-3 years receiving at least two topical fluoride varnish treatment and oral hygiene instructions.

Strategies:

1. 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.
2. Provide promotional oral hygiene kits to give out in the month of February, Children's Dental Health Month.
3. Record a Samoan PSA video promoting what to expect when getting a fluoride varnish treatment at the Well Baby Clinic.

ESMs

ESM 13.2.1 - **Percent of children 0-3 years receiving fluoride varnish at least twice a year.**

Domain: Child Health

PRIORITY 4. Developmentally appropriate care and services are available for all children.

SPM 2. Percent of children ages 3 who are up to date with their age appropriate routine vaccinations.

- **promote immunization coverage for all children**

OBJECTIVE 2.3.1. By July 2023, increase immunization coverage by 2% children ages 3 years who are up to date with their routine vaccinations.

Strategies:

1. Partner with the Immunization Program to produce two Public Service Announcements and advertise on local media outlets and social media.

2. Work closely with the Department of Education and Head Start to coordinate all students are fully vaccinated prior to school entrance.

ESMs

ESM 4.3.1: Percentage of school coverage receiving lists of students who are up to date (roster update and reminders).

ESM 4.3.2: Percentage of MCH staff who have access and can update immunizations on WEBIZ.

ESM 4.3.3: Percentage of MCH clients receiving reminder calls, transportation and care coordination to improve immunization compliance.

Domain: Child Health

PRIORITY 5. Reduce Acute Rheumatic Fever and Rheumatic Heart Disease.

SPM 3. Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.

OBJECTIVE 5.1: Increase by 2% the percentage of children ages 4 - 17 years of age who are compliant with their scheduled Bicillin shots annually, by September 30, 2023.

Strategies:

1. Continue to provide call reminders 1 week, then 1 day prior to the appointment date.
2. Continue to provide mass media campaigns in promoting RHD Clinic.
3. Establish RHD clinics at Leone and Amouli Health Centers.
4. Offer pick up and drop off at appointments.
5. Provide Care Coordination for children diagnosed with RF and RHD and ensure they are compliant with their antibiotic prophylaxis every 21 days.
6. Enter encounters and Bicillin shots in SILAS for tracking and monitoring. This will generate the RHD registry.

ESMs

ESM 5.1: Percentage of RHD clients who are compliant with their bicillin antibiotics prophylaxis.

ESM 5.2: Percentage of providers attending CME session on RHD updates.

ESM 5.3: Percentage of RHD clients are in the RHD Registry.

OBJECTIVE 5.2: By August 30 2022, a group of local workforce receives training on screening school age children with basic echocardiograms for Rheumatic Heart Disease.

Strategies:

1. Coordinate with the Preventive Health Grant Coordinator to fund a cardiac sonographer to train local workforce.
2. Provide care coordination with parents and schools to get children screened during training.
3. Ensure an MCH PulmonaryCardio Technician is hired to attend the training.

ESMs

ESM 5.2.1: Number of local workforce trained in basic echocardiogram screening for RHD.

State Outcome Measure: Percentage of children ages 5-17 who have received a cardiac echo to confirm for RF and RHD.

Adolescent Health

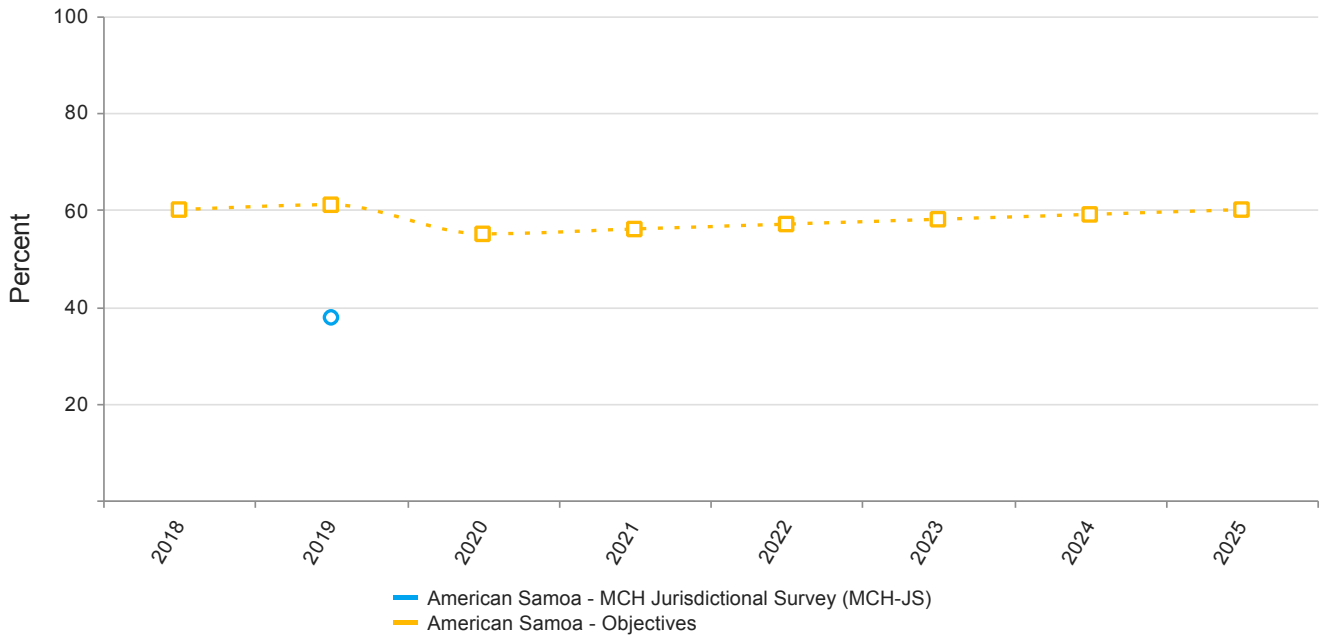
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	Data Not Available or Not Reportable	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	Data Not Available or Not Reportable	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	Data Not Available or Not Reportable	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	0 %	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	MCH-JS-2019	0 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	69.6 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 10
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)	MCH-JS-Age 0-2	Data Not Available or Not Reportable	NPM 10
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)	MCH-JS-Age 10-17-2019	24.9 %	NPM 10
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)	NSCH	Data Not Available or Not Reportable	NPM 10
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)	WIC-2018	14.0 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
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)	YRBSS-2013	41.2 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	38.4	NPM 10

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	61	55
Annual Indicator	37.7	37.7
Numerator	2,923	2,923
Denominator	7,753	7,753
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			60	61	55
Annual Indicator	70.8	77	39.8	54.2	12.9
Numerator	4,561	5,049	2,555	3,321	687
Denominator	6,440	6,555	6,414	6,127	5,340
Data Source	AS CHC and Immunization Program	AS CHC and Immunization Program	Immunization Office Registry Web IZ US Census Int.	CHC UDS Report	CHC UDS Report
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	56.0	57.0	58.0	59.0	60.0	61.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of adolescents who have a wellness check-up passport.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		0
Numerator		0
Denominator		6,197
Data Source		MCH TITLE V
Data Source Year		2020
Provisional or Final ?		Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	35.0	40.0	41.0

ESM 10.2 - Percent of children and adolescents enrolled in the Intersections Inc. Sexual Health Education and Ta'iala Peer Leaders had an annual medical check-up.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	51.0

ESM 10.3 - Percent of adolescents who have heard or read through mass media campaign the importance of an annual check-up.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	51.0

State Performance Measures

SPM 3 - Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			29	30	31
Annual Indicator	34.8	43.6	15.1	9.4	0
Numerator	49	60	20	12	0
Denominator	14,071	13,749	13,248	12,768	11,286
Data Source	RHD registry 2016	RHD registry	MCH RHD Registry (BYU, OSHU, MCH)	MCH RHD Registry (BYU, OSHU, MCH)	MCH RHD Registry
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	32.0	31.0	30.0	14.1	12.0	0.0

State Action Plan Table

State Action Plan Table (American Samoa) - Adolescent Health - Entry 1	
Priority Need	
Communities and providers support adolescents' physical, mental and emotional health.	
NPM	
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	
Objectives	
Increase the percentage of adolescents with a well visit by 2% every year, from 48.2% in 2019 to 58.2% in 2024.	
Strategies	
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 schools to refer clients and students for annual medical check-ups.	
ESMs	**Status**
ESM 10.1 - Percent of adolescents who have a wellness check-up passport.	Active
ESM 10.2 - Percent of children and adolescents enrolled in the Intersections Inc. Sexual Health Education and Ta'iala Peer Leaders had an annual medical check-up.	Active
ESM 10.3 - Percent of adolescents who have heard or read through mass media campaign the importance of an annual check-up.	Active

NOMs

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

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 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

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Last Year (2020) Accomplishments

The Rheumatic Heart Disease program in American Samoa is a program within the MCH Title V program that collaborates with multiple partners across the government and community to address this preventable yet debilitating condition among our children and adolescent population. Partners include the Preventive Health & Health Services Grant, the Non-Communicable Disease Program, the Federally Qualified Community Health Centers (FQHC), and the community at large with donations and support from local businesses, churches, and schools. These partners offer support to assist the ongoing bicillin clinic at the health centers as well as to promote healthy heart initiatives and prevention education of RHD in the territory.

With a caseload of 155 children and adolescents receiving bicillin every 21 days, ASMCH was adamant in advocating for clinics to continue serving this population despite challenges that were brought about with the start of the pandemic. Clinics and health providers were expected to work extra hours and serve more people who were coming in for COVID vaccinations, COVID testing, and manning border patrol efforts to keep COVID outside of our borders.

Due to COVID-19 and the closing of borders, the cardiology teams from the mainland were unable to travel to American Samoa. Therefore, the screening and the assessment for children and adolescents with RHD were put on hold. However, the bicillin clinic continued with scheduling clients to comply with appointments and doctor visits throughout the year.

On September 29, 2020, the RHD program initiated a World Heart Day wave with an invitation extended out to the Public Elementary and High Schools especially the community to come out and help us celebrate World Heart Day. The highlight for World Heart Day last year was acknowledging our compliant RHD clients and celebrating all the Heart heroes and star donors we have in our community. Parents and families, providers from both LBJ and DOH, legislators, church leaders, and the business community representatives were all present at this event. A few months after this event, donations came from these different sections of the community to support RHD efforts, which amounted to more than $21,000.00. These funds will be utilized to sustain bicillin purchase from our off-island vendors, as well as maintaining equipment and supplies needed to sustain RHD prevention work.

Another health issue that has recently become a huge concern in the community is the increase of suicide among young teenagers and adolescents. Suicide was reported at high rates in 2020 among this population, prompting government leaders to take action and address this problem immediately. A task force was created in which members consisted of both public and private citizens; meeting to address this crisis.

The ASMCH team was presented an opportunity to apply for an AMCHP funding to utilize telehealth as a tool to address any health priority during the COVID pandemic. Suicide among teenagers and adolescents was the health priority the ASMCH team used to apply for this funding and was granted $100 thousand to use for this purpose in the duration of four months. This opportunity enabled Title V to take lead in creating a system of referral utilizing telehealth systems to connect high schools to counselors and behavioral health specialists who can help identified at risk students who are considering suicide.

Title V leaders had an understanding that although there were services available in the community in both public and private sectors, there was a lack of teamwork within each sector. Through understanding what non-profit groups was capable of offering and executing memorandums of understanding (MOUs) with these groups so that expectations from both parties were clear and concise, Title V was able to gain commitment and share resources with these partners to address this suicide dilemma. In addition, by offering the same opportunity to government programs and departments who work directly with this age group, a consensus of working together was the ultimate product of this effort. Government departments are now working closely with existing non-profits groups using resources and equipment purchased through the Title V AMCHP funding to address the suicide problem in American Samoa. More

importantly, adolescents and teenagers will now have a system in place in their own schools to access counselors and behavioral health specialists if they are in need of their services.

ASMCH has also partnered with another local non-profit group called Intersections Inc., who train young individuals to become peer leaders/mentors addressing social and health issues that impact their young lives on a daily basis. This group of young individuals will be responsible to produce videos and social media platforms to address issues such as suicide to their own peers. Also, a portion of this AMCHP fund went into purchasing a telecommunication system that is now used to operate the 24 hour 9-8-8 Suicide Hotline by local operators (consists of ASMCH staff and DHSS staff), as well as advertisements on local radio stations to the public regarding the 9-8-8 Suicide Hotline.

Strengths

- **Free Bicillin**: Families are able to access Bicillin prophylaxis at no cost due to the partnership of MCH and CHC and their application for the 340B Discount Program. Children, Adolescents, as well as some adults are able to access this preventive care through the Primary & Well Child Clinics.
- **Partnership**: We have great partners in the RHD prevention effort. The Oregon Health and Science University (OHSU) and Brigham Young University (BYU) team were always able to travel to American Samoa. Unfortunately, due to COVID-19 and strict quarantine requirements- our partners are unable to travel for two consecutive years to screen our RHD clients.
- **Increase Bicillin compliance**: Bicillin adherence was a constant challenge for many of the children and adolescents in the RHD program. Through close monitoring and consistent reminders, compliance has increased close to 100% for majority, if not all, of those in the bicillin program. MCH/RHD staff provides support through phone calls, transportation to and from the clinic, as well as counseling support for parents and adolescents who have a difficult time complying with secondary prophylaxis.
- **Staff Coverage**: All of MCH/RHD staff have been cross-trained to provide coverage if one is unable to carry out assigned duties due to unforeseen circumstances.
- **9-8-8 Suicide Hotline:** Despite COVID-19, the numbers of suicide cases were starting to rise. Therefore, the MCH staff partnered with the Behavioral Health Services Program and the Department of Human and Social Services (DHSS) to work on the Suicide Hotline that's available to the community. Training for potential phone operators was conducted over a period of 3 days to educate and prepare them on how to address incoming calls related to suicide, mental health/illness or domestic violence/abuse.

Challenges

- There is still no dedicated funding for RHD efforts in the territory although it remains a serious health threat to young children and adolescents, island wide.
- Staff shortage: As the RHD program is gradually growing, more help is needed to support clinical efforts and to sustain the success of the program.
- Accessibility of RHD clients who live further away from Tafuna Family Health Center (TFHC) is a challenge. Due to staff and provider shortage, the Bicillin Clinic is only administered at the TFHC, however, there are clients who live on the opposite side of the island from where this health center is located. Those RHD clients will have to travel on public transportation for about an hour to get to the TFHC to receive bicillin. This is an issue the RHD/MCH program is looking into and working together with CHC for a solid resolution.

- Questionable competency of the behavioral health specialists who are present on island to meet the needs of the adolescent population in addressing suicide.

- The competency and availability of primary care providers to specify healthcare approaches that would benefit adolescents across the island and motivate them to regularly seek preventive care.

- The lack of commitment from leaders to spearhead youth initiatives that can make an impact in their young lives, such as drug abuse prevention. As well as getting young people involved in the planning phase and implementation of programs that can benefit their young lives.

- Not enough staff onboard to dedicate full attention to initiatives that address adolescent healthcare.

Adolescent Health - Application Year

Current activities for 2021

- The “Manumalo Alofa" Bicillin clinic operates within the Community Health Center yet managed by the RHD program in an on-going effort to help children and adolescents diagnosed with Acute Rheumatic Fever (ARF) and/or Rheumatic Heart Disease (RHD). Each child receives bicillin medication at no cost every 21 days, along with an overall assessment of their general health. Throughout 2021, the Bicillin clinic was able to provide care coordination to 153 children, more than half of which are adolescents. Two of our adolescent clients sadly passed away in 2020 due to unknown causes. ASMCH staff who work for the RHD program provide reminder calls as well as secure and reliable transportation for families in need of assistance. Currently, the clinic continues to operate every day of the week, whereas at the start of the pandemic, it was operating for a few days and during late afternoon hours. This was to accommodate the availability of staff at the health center due to the demands of the COVID operations. As the demand decreased, the clinic was then moved to operate during its daily hours, and throughout the entire week, with an MCH/RHD staff on site to ensure patients are receiving the necessary care required on a daily basis.

- Immunization for adolescents continues to be a challenge due to parents having less understanding about the available vaccines for this population. Since the Measles Outbreak, parents have become more informed about the importance of getting their adolescents immunized. With the COVID-19 pandemic, parents are informed of the age requirement for adolescents to receive the COVID-19 vaccine and are encouraged to bring their children in for vaccinations.

- ASMCH staff have been trained to be Suicide Hotline operators, working afterhours throughout the week to help cover shifts for the Behavioral Health Program. This hotline was established through a partnership between DOH and DHSS (Department of Human and Social Services) in efforts to address the hike in teenage suicide in 2020. Both departments, through collaboration with its internal programs, have maximized the available resources to assist in covering the hotline 24 hours, 7 days a week.

- The Title V program is leading an initiative through the assistance of an AMCHP telehealth grant to address suicide prevention among adolescents and teenagers in the territory. This initiative allowed for Title V to partner with local non-profit groups who target adolescents and their health issues. Through this partnership, the ASMCH program was able to equip all local high schools, both public and private, with a telehealth system. These telehealth systems enable schools to directly connect “at risk” students to counselors and professionals conveniently from their schools. Our non-profit partners will utilize a curriculum to identify these “at risk” students within the school and then proceed to make the necessary referrals. This effort has forged new partnerships between the non-profit groups and the Department of Education to address these ongoing concerns amongst the adolescent population.

Future Plans 2022

Domain: Adolescent Health

PRIORITY 6. Communities and providers support adolescents' physical, mental and emotional health.

NPM 10. Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

OBJECTIVE 10.1. Increase the percentage of adolescents with a well visit by 2% every year, from 54% in 2019 to 64% in 2024.

Strategies:

1. Initiate and support an adolescent peer group who will lead advocacy to the legislature about the "Healthy Schools Mandate" requiring all school children in Elementary and High Schools to receive a wellness check-up within 3 months prior to the start of every school year.
2. 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)
3. Collaborate with partners such as Intersections Inc., EPIC, Boys & Girls club, ASNOC, Faithbased Youth Organizations, Teen Challenge, DOE and Private schools to refer at-risk students to DOH for annual medical check-ups and follow up.
4. Create Behavioral Health and Suicide prevention PSA's with partners such as Intersections Inc., EPIC, Boys & Girls club, ASNOC, Faithbased Youth Organizations, Teen Challenge, DOE and Private schools.

ESMs

ESM 10.1 - Percent of adolescents who have a wellness check-up passport.

ESM 10.2 - Percent of adolescents who had an annual medical check up.

ESM 10.3 - Percent of adolescents who completed the Suicide Prevention Curriculum.

Domain: Adolescent Health

PRIORITY 6. Communities and providers support adolescents' physical, mental and emotional health.

NPM 10. Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

OBJECTIVE 10.1. Increase the percentage of adolescents with a well visit by 2% every year, from 54% in 2019 to 64% in 2024.

Strategies:

1. Initiate and support an adolescent peer group who will lead advocacy to the legislature about the "Healthy Schools Mandate" requiring all school children in Elementary and High Schools to receive a wellness check-up within 3 months prior to the start of every school year.
2. 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)
3. Collaborate with partners such as Intersections Inc., EPIC, Boys & Girls club, ASNOC, Faithbased Youth Organizations, Teen Challenge, DOE and Private schools to refer at-risk students to DOH for annual medical check-ups and follow up.
4. Create Behavioral Health and Suicide prevention PSA's with partners such as Intersections Inc., EPIC, Boys & Girls club, ASNOC, Faithbased Youth Organizations, Teen Challenge, DOE and Private schools.

ESMs

ESM 10.1 - Percent of adolescents who have a wellness check-up passport.

ESM 10.2 - Percent of adolescents who had an annual medical check up.

ESM 10.3 - Percent of adolescents who completed the Suicide Prevention Curriculum.

Children with Special Health Care Needs

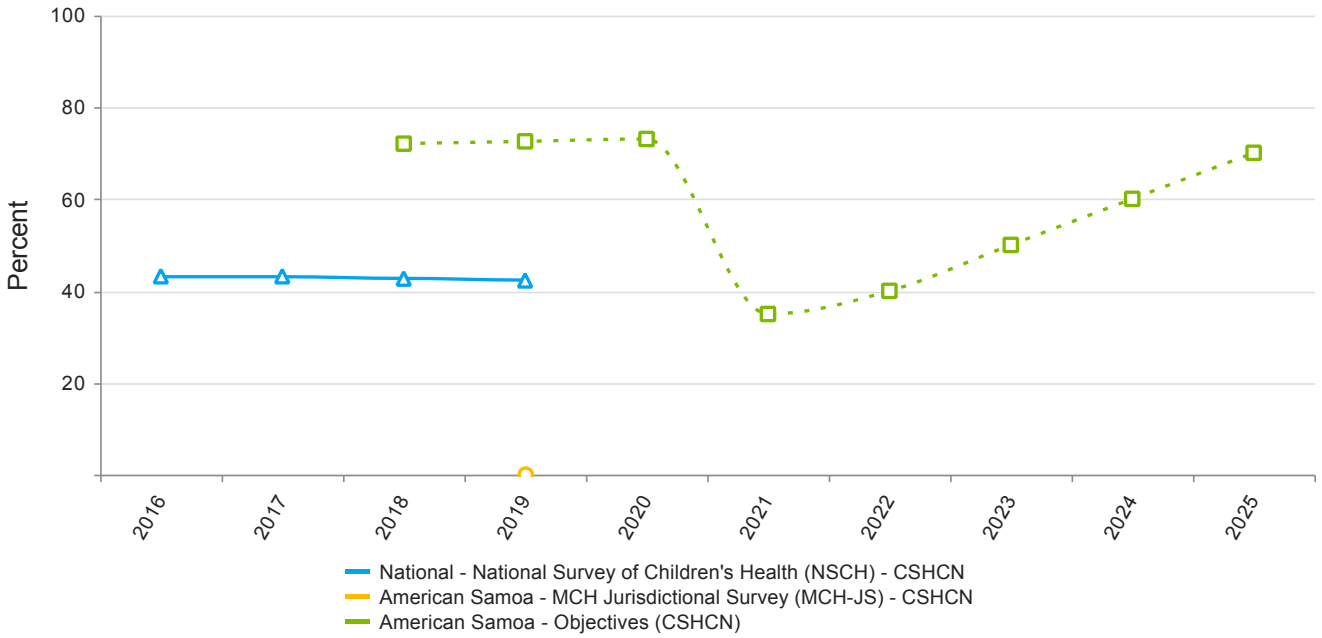
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	0 %	NPM 11
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	MCH-JS-2019	0 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	69.6 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	MCH-JS-2019	2.6 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH	Data Not Available or Not Reportable	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective	72.5	73
Annual Indicator	0	0
Numerator	0	0
Denominator	1,504	1,504
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			72	72.5	73
Annual Indicator	71.8	74.3	43.3	60.6	33.3
Numerator	18,366	19,099	7,815	10,553	1,779
Denominator	25,579	25,722	18,063	17,418	5,340
Data Source	ASCHC and Immunization Program	ASCHC and Immunization Program	MCH CSHCN, Part C, CHC UDS Report	CHC UDS Report	CHC UDS Report
Data Source Year	2016	2016	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	40.0	50.0	60.0	70.0	75.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	40.0	60.0	80.0	90.0	100.0

ESM 11.2 - Percent of Providers attending Autism Screening Training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	60.0

ESM 11.3 - Percent of CSHCN families receive transition training.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	15.0	20.0

State Action Plan Table

State Action Plan Table (American Samoa) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Improve System of Care for Children and Youth with Special Health Care Needs.	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
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.	
Transition Objective.	
Resource Center Objective.	
Strategies	
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.	
ESMs	**Status**
ESM 11.1 - Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population	Active
ESM 11.2 - Percent of Providers attending Autism Screening Training	Active
ESM 11.3 - Percent of CSHCN families receive transition training.	Active

NOMs

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

Children and Youth with Special Health Care Needs: Annual Report

Last Year (2020) Accomplishments

The Children and Youth with Special Health Care Needs (CYSHCN) Program focuses on continually improving the healthcare system for their clients. The CYSHCN program ensures that the CYSHCN population receives the necessary services needed to improve client health daily, in consideration of a holistic approach. The CYSHCN program continues to provide and promote available services to each CYSHCN client and their families. These services include but are not limited to Dial-a-Ride vouchers available through collaborations with the Leo o Aiga program to assist clients & their families who need transportation support to acquire healthcare services. CYSHCN caseworkers provide translation support during doctors' appointments, consult with families on where to access existing services in the community that can meet their needs, as well as telehealth connections if services are not available on the island but can be accessed via telehealth.

In 2020, the CYSHCN team continued to provide care coordination for clients within the program by diligently checking on program clients and their families from the start of the pandemic to the present day on their wellbeing and health needs. It was key to have a thorough understanding of how the families were dealing with the changes in the community because of COVID restrictions. There were families who were stranded in the mainland for quite some time due to COVID and the separation of families was difficult for many, especially for a society that thrives on communal living and family structure. The CYSHCN team made sure to step in to provide clarification or mediation if necessary on their clients' behalf if there were issues with healthcare providers or inter-governmental agencies. Due to COVID-19, most services provided were offered through phone calls when restrictions were implemented by the government. Towards the last 6 months of 2020, these restrictions were reduced to a more relaxed state and people were able to meet in person again.

In preparation and prevention for COVID-19, the entire healthcare system protocols for in-patient services were reconstructed in order to implement safety regulations given by the CDC. Since the COVID-19 pandemic, clinicians have spent a large portion of their time in task force meetings, vaccination sites, and other efforts concerning the pandemic. These circumstances created barriers for this population to acquire much needed healthcare services from the existing system.

The DOH and LBJ clinics only accepted patients who were scheduled ahead of time, turning away anyone who walked in. The CYSHCN team had a difficult time scheduling clients to be seen by clinicians due to new regulations and continual change of hours within the clinics. The healthcare providers emphasized the importance of scheduling only those in dire need of care, countering the efforts of the CYSHCN team in scheduling clients for preventive visits. Besides the challenges presented through providing services for clients, the CYSHCN team contributed time to COVID-19 efforts. Time dedicated to COVID-19 efforts prompted confidence and awareness among our staff to promote COVID-19 vaccination services to our clients and their families. Additionally, the CYSHCN team also further supported these efforts by working the COVID drive-thru vaccination events, scheduling clients who are homebound for vaccinations within the home, referral to clinicians for concerns or questions, and registering clients additional services per request.

Throughout 2020, the Zika Navigators completed the transition for Zika clients who were to exit the Zika program and enter into the CYSHCN program because they continue to need support and specialized services. The Zika client Navigators scheduled screenings and immunization appointments for clients before the island implemented COVID-19 regulations. Once the regulations for COVID-19 were in effect, the Zika Client Navigators closely assessed the Zika clients via telecommunications to determine if there were appropriate programs available that would cater to each clients' long term health needs. The Zika Client Navigators organized a final home visit to each Zika client to officially close out each case and provided each exiting client with a tote bag filled with age appropriate items for learning and development.

Strengths

- CYSHCN coordinators have developed a rapport with all specialty clinics at the LBJ hospital to include ENT, Eye Clinic, Orthopedic, Pediatric, DOH Physical Clinic, and Dental for CYSHCN visits
- CYSHCN caseworkers are assisting clients and families who may need help with enrolling into other agencies that would be of great help to their child with special needs.
- CYSHCN coordinators provide support for program clients and families during the COVID-19 restrictions testing and vaccine needs, if eligible.
- CYSHCN coordinators worked alongside the Zika Client Navigators to share information, ideas and resources to improve services.
- The CYSHCN team, through offering consistent service, is building strong bonds with clients and their families.
- The CYSHCN Program continues to partner with the Parents Network of Children with Special Needs (PCSN) throughout the year to support activities and initiatives for this population.
- The CYSHCN Program continues to work closely with Medicaid and the LBJ Hospital to determine how to maximize resources and best support pertinent medical needs of the CYSHCN population without causing further burden onto the client and family.

Challenges

- CYSHCN coordinators have a hard time contacting clients due to relocation or change of contact information without providing updated information.
- Some parents/caregivers to CYSHCN clients may have difficulty understanding services that are offered in the community yet are not comfortable to ask for clarification.
- Limited resources and specialty care for CYSHCN (PT, OT, Speech Therapy, Neurology, etc.)
- There is currently no system in place to account for all children with special needs. The count for children in the school system with an Individualized Education Plan (IEP) includes children who are identified to have a learning disability and not necessarily a developmental disability, Therefore, this number could be an overestimate of the CYSHCN population.
- Limited advocacy from families of CYSHCN due to lack of understanding pertaining to rights and services that are beneficial to this population.
- Providers are not entirely comfortable with serving the CYSHCN population due to lack of training in specialty care.
- Interagency services for people with special needs need to be restored and strengthened, in order to be prime advocates for people with special needs, including children.
- There needs to be more caseworkers hired to handle the growing number of children with special needs in

the territory. The two caseworkers presently employed for Title V are not sufficient to provide quality care coordination for all families and their children and youth with special needs.

Children and Youth with Special Health Care Needs: Application Year

Current Activities (2021)

- The CYSHCN coordinators continue to schedule appointments for clients through community health centers such as dental appointments, and LBJ Hospital through the ENT/Eye Clinic and Orthopedic clinic
- The CYSHCN coordinators are assisting families who need help with translation/interpretation during their appointments.
- The CYSHCN coordinators continue to support COVID efforts by scheduling CYSHCN clients who are eligible for the vaccine.
- The CYSHCN Program is continually collaborating with the Family to Family Health Information Center to increase parent and family participation with the center and to determine advocacy activities that would best fit the needs of families and their child/youth.
- The CYSHCN program continues to collaborate with PCSN, in an effort to build a community for people with special health care needs.
- In the process of solidifying MOU with LBJ hospital in order to assist clients with services that are not covered under Medicaid.

Future Plans (2022)

- Hire additional CYSHCN caseworkers for this program to help manage cases thoroughly
- Collaborate with the Parent Center to create an individualized care plan (ICP) for each program client that will guide the care provided and needed by the client.
- Revise Standard Operating Procedures (SOPs) on how to implement ICPs and engage families/parents to promote Family/Patient centered care models and preparation for adult transition.
- Offer training for providers on Family/Patient Centered Care.
- Engage LBJ Pediatricians and other specialists with WBC providers in collaborative coordination for CYSHCN. Also, a clarification will be needed to improve communications and referral protocols for CYSHCN caseworkers when providing care coordination.
- Provide annual updates on care coordination services, challenges and success stories during CME sessions with medical staff.
- Collaborate with the Leo o Aiga Health Information Center to implement at least three community outreach mini-workshops in the west, central and east districts for families and providers to share services, challenges and success stories.

Cross-Cutting/Systems Building

State Performance Measures

SPM 4 - Maternal and Child Health Centralized Database System in SILAS

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	SILAS	SILAS
Data Source Year	2019	2020
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

State Action Plan Table

State Action Plan Table (American Samoa) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Establish a Maternal and Child Health Centralized Database at the Department of Health.
SPM
SPM 4 - Maternal and Child Health Centralized Database System in SILAS
Objectives
By 2021, all MCH data needs are consolidated and input in SILAS including vital statistics.
By 2024, all MCH data needs are collected in a centralized database that Public Health Surveillance Office can access in a timely manner.
Strategies
Establish monthly meetings for Maternal and Child Health Epidemiology and Surveillance to build the centralized database and reporting templates.

Cross-cutting/ Systems Building: Annual Report

Priority Need: Establish a Maternal and Child Health Centralized Database at the Department of Health.

Last Year (2020) Accomplishments

Even though there was no Cross-cutting Domain in 2020, the MCH-Zika Services Initiative had identified the need to **"Establish a Maternal and Child Health Centralized Database at the Department of Health."** Towards the end of 2019 and earlier last year, MCH Epidemiology team collaborated with Family Trac and SILAS partners to determine data-sharing agreements, annual fees and types of MCH data templates to build in SILAS. Partners included ELC, Helping Babies Hear and Helping Hands. A sole source with Family Trac, who administers the electronic web-based SILAS Database, was established. Both SSDI and MCH-Zika Services grants were utilized to establish the MCH Database.

Linkage of data systems has long been identified as a need to improve MCH surveillance, and American Samoa Title V will continue to prioritize linkage of MCH data sources. Epidemiology staff will continue to implement probabilistic matching to improve the linkage rate and quality for the infant birth and death certificates.

One of the main strengths in 2020 was having MCH Epidemiology working closely with Family Trac to build MCH templates in SILAS. Having Measles Outbreak and preparing for the COVID-19 pandemic slowed down the launching of the MCH Database to January 2021.

SSDI Initiative was also instrumental in building and improving MCH Data Capacity as shown in the table below.

Objectives	Activities	Progress
Goal 1: Build and expand MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in ASMCH, including assessment, planning, implementation, and evaluation.		
1.1. The MCH Data Matrix will be updated with all NPMs, SPMs, and NOMs and reported quarterly by the MCH Title V Program to Program Director and key partners via emails and hard copies.	1. All data required to report on MCH Title V annual reports will be updated by the MCH Surveillance Team (Data Tech and Epidemiologist). (Jan-Mar, Apr. – June, July- Sep, Oct-Dec) 2. Once the MCH Data Matrix is completed and reviewed by the core group then a Stakeholders Meeting is called and data presented to them for feedback and	Ongoing Frequent Stakeholders meetings were accomplished throughout the year to complete the Five Year Needs Assessment. Title V program staff completed about 5 meetings in total. They were done face-to-face in focus groups, one to one key informant interviews, virtual population domain workgroup meetings etc.

	recommendation. 3. A fact sheet with past year data dashboard is included in the executive summary of the Title V annual report and application and disseminated to other partners and the community for feedback.	
1.2. All quarterly reports will be compiled and the data matrix will be updated and presented to the MCH Data Core Workgroup by the end of May of every year.	4. MCH Data Core Workgroups will be called to review the MCH Data Matrix prior to the Stakeholders meeting in June of every year.	Accomplished.
1.3 Key Partners are called for meetings twice a year to review and assess key findings on state priorities and update program activities, every last Thursday of January and June, annually.	• Supporting Title V MCH Block Grant program data needs associated with AS Title V MCH Block Grant 5-year Needs Assessment process, including selection of the state's priorities, as well as ongoing interim needs assessment activities.	Smaller core group meetings were carried out throughout the year. One final meeting was done face-to-face on August 19-20 to present all findings for the Needs Assessment. SSDI core datasets were highlighted in annual trends.
Goal 2: Provide partnership and on-site support for the development and implementation of a data collection tool/process that will enable tracking of Title V MCH Block Grant National Performance Measure (NPM) data.		
2.1 Complete and update SSDI Data Collection Standard Operating Procedures	• Collaborating and providing on-site support for an MCHB-initiated effort to develop and implement a data collection tool/process that will assist jurisdictional Title V MCH Block Grant programs in reporting and	Current SOPs completed in 2018-2019 are currently being utilized.

•	tracking data needed for the Title V MCH Block Grant NPMs. - This will assist in initiating an SOP for the data collection process to execute the MCH Data Matrix Tool.	
2.2. Utilize the CRVS Workgroup to assess and review Vital Stats and provide recommendations for program activities by January 30 and May 30, annually.	• Generate an annual work plan that would include continuous assessment of vital stats at least quarterly and provide recommendations for improving data collection and efforts to improve on related NPMs, NOMs and ESMs.	Currently, the CRVS workgroup that used to be spearheaded by the Chief Statistician of the Department of Commerce, has not been active in the past 2 years since conducting the 2020 Census. Meanwhile, the MCH Surveillance team continues to work closely with the Territorial Epidemiologist, Dr. Aifili Tufa, to build the centralized database to include vital statistics and other MCH performance and outcome measures.
2.3 Assist the Public Health Surveillance office to link MCH to the SILAS program HBH is utilizing to produce an electronic birth defect registry by December 30, 2018.	• Work closely together with these two offices to ensure that CDC funds to build a birth defect registry is completed and is functional.	Ongoing correspondence with Family Trac, formerly known as Scanlan Tech to build MCH centralized database in SILAS.

Current Activities (2021)

MCH Database was released on January 23, 2021 and Ad Hoc reports were available on Births and Postpartum women. CYSHCN Client Navigators received their access in March and were then able to enter daily encounters. Title V is currently working on perfecting MCH data reports, retrieving birth records from a spreadsheet and being able to monitor, track and determine certain NOMs and NPMs from SILAS.

Strengths

- All births of 2020 are available on SILAS
- Family Trac is based in the East Coast but responds to troubleshooting requests within 24 hours with flexible hours to have zoom meetings that are convenient to AS time.
- Easily retrieve well documented reports for each CYSHCN client

Challenges

- Because MCH database is new in SILAS, program staff need to establish a monthly schedule to meet with program developer and IT administrator to solve and improve the system
- Need to build active and inactive tabs in the CYSHCN template
- Mortality data was not available for 2019 and 2020 as ELC and Public Health Surveillance staff are still in the

process of inputting Death Certificates into SILAS.

- MCH Data reports have yet to be disseminated to partners and key stakeholders as planned. Epi teams and Title V administration are tasked to COVID-19 planning, surveillance, testing, and vaccination campaigns.

Cross-cutting/ Systems Building: Annual Report

Priority Need: Establish a Maternal and Child Health Centralized Database at the Department of Health.

2022 Application:

Goal 1: Collaborate with Family Trac to ensure off-site support for the development and implementation of a data collection tools/process in the MCH Database in SILAS.		
1.1 Establish Standard Operating Procedures for MCH Title V data entry, collection and reporting on SILAS.	1. Ensure Title V staff have standing monthly meetings with Family Trac to discuss improvements to data entry of daily encounters. 2. Collaborating and obtaining off-site support from Family Trac to develop and revise ad hoc reports on SILAS to assist with Title V MCH Block Grant reporting. 3. Establish Data-sharing agreements with all program partners in SILAS.	**MCH Data Core Workgroup:** 1. Anaise Uso - Program Coordinator 2. Ruta Ropeti – MCH Epi Tech 3. Ipuniuesea Eliapo – CSN/RHD Coordinator 4. CSHCN Team - Emalaine Lam Yuen, Fetina'I Taitai 5. Helping Hands – Bethany Toelupe 6. Helping Babies Hear – Rosanne Felise 7. Dr. Aifili Tufa – DOH Epidemiologist
1.2 Assist the Public Health Surveillance office to link MCH to Vital Stats in SILAS	Work closely together with Public Health Surveillance Office and Family Trac to ensure both Births and Deaths data are accessible to Title V.	**Same MCH Data Core Workgroup**
Goal 2: Build and expand MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in ASMCH, including assessment, planning, implementation, and evaluation.		
2.1. Update and disseminate MCH Data Matrix by June 30, 2022.	1. All data required to report on MCH Title V annual reports will be updated by the MCH Surveillance Staff and disseminate to all MCH Core Workgroup members, quarterly . (Jan-Mar, Apr. – June, July- Sep, Oct-Dec)	**SSDI Data Tech/MCH Epi Tech** **Title V Program Director** **MCH Data Core Workgroup:** 8. Anaise Uso -

	2. Establish MCH Stakeholders meetings twice a year to present findings for feedback and recommendation, on January 31 & May 30, 2022 3. A factsheet with past year data dashboard is included in the executive summary of the Title V annual report and application and disseminated to other partners and the community for feedback by June 30, 2022.	Program Coordinator 9. Ruta Ropeti – Data Tech 10. Ipuniuesea Eliapo – CSN/RHD Coordinator 11. Dr. Faiese Talafu – Pediatrician 12. CSHCN Team - Emalaine Lam Yuen, Fetina'I Taitai 13. MIECHV – Merenatie Liua 14. Helping Hands – Bethany Toelupe 15. Helping Babies Hear – Rosanne Felise 16. Yolanda Masunu – Immunzation Program Coordinator 17. Dr. Aifili Tufa – DOH Epidemiologist 18. Family Representative – Scandra Scanlan **Key Partners:** • Territorial Epidemiologist, Aifili Tufa • CHC Executive Director, Elizabeth Ponausuia • WIC Breastfeeding Coordinator, Luana Leiato • DOE Health Coordinator, Magdalene Auanae • Child Care Assistant Director, Louisa Tuiteleleapaga

		• SPED Director, Teresa Atuatasi • CHC Pediatrician, Dr. Talafu • LBJ Pediatrician, Dr. Maria Gayapa • LBJ OBGYN Chiefs, Dr. Muasau-Howard • DHSS Behavioral Health Director, Lupe Sunia • AHEC Coordinator, Monica Afalava • DOC Chief Statistician, Vai Filiga • LBJ MIS Chief, Ray Tulafono • LBJ record Office Manager, Suafa Toluao • LBJ Coder, Judy Payes • UCEDD Director, Tufa Tua-Tupuola • Intersections Inc. Director, Lia Seui • Vital Stats Registrar, Taifita Solomona • LBJ Dental Chief, Dr. Leute Leota

III.F. Public Input

PUBLIC INPUT 2020

This year, ASMCH team used a variety of opportunities to collect public input to help revise the statewide five-year needs assessment and identify strategies that will help guide the work for this program. These opportunities included committee meetings, advisory councils, and forums that include community members who provide valuable insight to the quality of services programs like Title V provide for women and children. Perspectives from both the professional side and the community were favorably considered in revising the State Action plan for the following years. Their input and experience directly informed this program of present issues and priority needs that need to be considered and included in American Samoa Title V five-year application.

The following are meeting opportunities in which ASMCH staff were able to share on selected priorities and gain feedback on the State Action Plan. Also note the duration of each meeting throughout the year.

NCD Meetings	Twice
Cancer Prevention Programs Roadmap	Once
Preventive Health Meeting	Twice
Mana Dashboard Meeting	Once
Women's Health Meeting	Once
Pediatric Rounds	2x weekly
COVID-19	Weekly, daily
KLM Meetings	Weekly, Monday afternoons
Story Telling of Families of Children with Autism	Once
CMEs	Every Tuesdays
F2F Trainings	Once
Protect As One Festival	Once

The following individuals and stakeholders contributed to this year's reporting:

Stakeholders	POC
BCCP	Jasmay Willis
CCCP	Elizabeth Fano
CHC	Dr. Fuimaono, , Dr. Talafu, Dr. Mirella
LBJ Pediatric Clinic	Dr. Naomi Dane, Dr. Gayapa
Tobacco and Diabetes	Fara Lesa, Lydith Powell
COVID-19 Vaccination Workgroup	Dr. Fracnine
Pharmacy	Dr. Francine
Immunization	Yolanda Masunu
EPRD	Ben Sili
Helping Hands	Rosanne Felise
HBH	Bethany Toelupe
ELC	Dr. Aifili John Tufa
Lab	Cathrine Motalbo
HIV/STD	Ina Sagaga
MIECHV	Merenaite Liua
EPIC	Toleafoa Kathryn McCutchan
Intersections	Li'a Seui
Behavioral Health	Dr. Julia Foifua, Siitia Lemusu
WIC	Luana Leiato
Nursing Hiomevisit	Sandy Ahoia
NCD	Jacki Tulafono, Dr. Fiona, Dr. Eminoni

A Public Notice was also posted on the ASDOH and ASMCH Facebook pages to also acquire general public feedback on the grant application. It reached 124 community members. We had not yet received an email to ask questions and provide feedback.

A brief summary of the Title V FY 2021 application and State Action Plan was sent out via email to listed stakeholder members and interested legislators. They are all asked to provide necessary feedback through email or by phone call when they've completed reviewing submitted documents.

After the application is submitted, ASMCH will continue to work with entities representing advocates, advisory bodies, providers and consumers to receive input on the programs, policies, reports and plans included in the Title V application. For example, the Children's Special Health Care Needs (CSHCN) Division routinely works with the Parent Network for children with special needs, Helping Hands Early Intervention and SPED. All these partners provide information and support to families and input on CSHCN program operations. By receiving ongoing feedback and recommendations, we will refine current policies and SOPs and thus promote awareness to assure that services reflect the voices of individuals with special health care needs and their families.

III.G. Technical Assistance

2020 Technical Assistance

Due to COVID-19, any training or technical assistance provided were all done virtually. Through these virtual calls, the American Samoa Maternal and Child Health Program and the TA share progress notes and receive support on projects that were done throughout the year. The American Samoa Maternal and Child Health Program had the opportunity to learn best practice virtually in terms of successes and lessons learned in planning and implementing the Title V Five- Year Needs Assessment. American Samoa agrees with the rest of their US affiliated neighbors in the Pacific that these TA meetings benefit and positively impact each of their MCH Programs. These meetings not only strengthen the MCH workforce but it also helps build its competencies and building skills.

Since the closure of borders in American Samoa, ASMCH team has been using zoom to hold meetings with off-island consultant and project officers. In working with AMCHP in addressing suicide in American Samoa, our team was able to identify a consultant to help with our goal to establish a Blood Spot Screening program for our newborns. A technical assistance request is in the process for Title V support as well as AMCHP.

Currently, we are in the initial stages of planning and getting paperwork completed. We recognize that this will be a huge uptaking but will be a rewarding as it will help save the lives of our babies. We anticipate to learn a lot from this project, but also will challenge ourselves to apply all the skills we've acquired from past trainings and learning opportunities through Title V work.

2021 Technical Assistance Requests:

1. Provide process guidelines for establishing a Newborn Metabolic Screening in American Samoa. This will include federal partners, national laboratories, CSHCN experts etc.
2. Ongoing learning opportunities and technical assistance related to identification, refinement and assessment of ESMs.
3. Medical Home support for CSHCN.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IAA_Title V_Title XIX.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MOU DOH EPIC Telehealth project signed.pdf

Supporting Document #02 - MOU_Telehealth_Signed.pdf

Supporting Document #03 - DOH_LBJ MOU DRAFT 01 MCH_RJM Edit_1 _080921.pdf

Supporting Document #04 - Acronyms and Defenitions.pdf

Supporting Document #05 - MOU DAR-Leo O Aiga.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - ASMCH Org Chart_9_1_21.pdf

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: American Samoa

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 494,000	
A. Preventive and Primary Care for Children	$ 150,000	(30.3%)
B. Children with Special Health Care Needs	$ 148,200	(30%)
C. Title V Administrative Costs	$ 0	(%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 298,200	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 390,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 390,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 318,604		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 884,000	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 41,017	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 925,017	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Zika Maternal and Child Health Services Program	$ 41,017

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 485,500		$ 490,243	
A. Preventive and Primary Care for Children	$ 145,900	(30.1%)	$ 228,192	(46.5%)
B. Children with Special Health Care Needs	$ 160,000	(33%)	$ 151,630	(30.9%)
C. Title V Administrative Costs	$ 0	(%)	$ 0	(%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 305,900		$ 379,822	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 364,125		$ 390,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 364,125		$ 390,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 318,604				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 849,625		$ 880,243	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 400,000		$ 333,584	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 1,249,625		$ 1,213,827	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Zika Maternal and Child Health Services Program	$ 350,000	$ 308,982
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000	$ 24,602

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

Field Note:
MCH Staff worked after-hours to accommodate the 988 Suicide Prevention Hotline. This was due to rise in adolescent and young adult suicide rates in 2020. Title V staff were trained to be operators in the 988 Suicide Hotline. MCH Title V 2020 Budget was revised and travel funds were recategorized into operating the Hotline after-hours as well team building sessions after as part of the training needs identified during the Needs Assessment.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: American Samoa

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 80,000	$ 48,558
2. Infants < 1 year	$ 100,000	$ 48,558
3. Children 1 through 21 Years	$ 150,000	$ 228,192
4. CSHCN	$ 148,200	$ 151,630
5. All Others	$ 15,800	$ 13,305
Federal Total of Individuals Served	$ 494,000	$ 490,243

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 50,000	$ 50,000
2. Infants < 1 year	$ 90,000	$ 90,000
3. Children 1 through 21 Years	$ 100,000	$ 100,000
4. CSHCN	$ 140,000	$ 100,000
5. All Others	$ 10,000	$ 50,000
Non-Federal Total of Individuals Served	$ 390,000	$ 390,000
Federal State MCH Block Grant Partnership Total	$ 884,000	$ 880,243

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: American Samoa

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 110,000	$ 100,726
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 30,000	$ 28,372
B. Preventive and Primary Care Services for Children	$ 30,000	$ 36,177
C. Services for CSHCN	$ 50,000	$ 36,177
2. Enabling Services	$ 350,000	$ 246,796
3. Public Health Services and Systems	$ 34,000	$ 142,721
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 100,726
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 100,726
Federal Total	$ 494,000	$ 490,243

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 90,000	$ 100,726
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 30,000	$ 28,372
B. Preventive and Primary Care Services for Children	$ 30,000	$ 36,177
C. Services for CSHCN	$ 30,000	$ 36,177
2. Enabling Services	$ 250,000	$ 239,274
3. Public Health Services and Systems	$ 50,000	$ 50,000
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 100,726
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 100,726
Non-Federal Total	$ 390,000	$ 390,000

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**

Field Note:
Nurse Practitioner Tele Hill who used to provide direct services for Children with Special Health care Needs only provide direct services for pregnant women in 2020. MCH Title V staff provide mostly enabling services through care coordination, health education, transportation, immunization and oral health screenings.

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: American Samoa

Total Births by Occurrence: 733 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	731 (99.7%)	7	0	0

Program Name(s)
Hearing Loss

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

A total of 733 births were entered on SILAS for 2020. Two fo those infants were not able to receive hearing screening because they passed away in NICU. A total of 731 received inpatient hearing screening before they were discharged from the hospital. Hearing screening occurred between 24 to 48 hours after birth. Five were referred for Early Intervention Services and none were confirmed for hearing loss.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Total live births per SILAS database.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2020**
	Column Name:	**Data Source Year Notes**
	Field Note: Data Source: SILAS. Stands for Share Integrate Link American Samoa.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Two babies were in NICU and passed away before Newborn hearing screening was done.	
4.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Seven babies did not pas their initial hearing screening and were given appointments to return after two weeks of discharge from nursery for another evaluation.	
5.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: None were confirmed hearing loss but were referred for early interventions.	
6.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Five of the 7 did not pass and hence were referred to ENT and EI for evaluations. None have cone back diagnosed with hearing loss.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: American Samoa

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	725	100.0	0.0	0.0	0.0	0.0
2. Infants < 1 Year of Age	733	100.0	0.0	0.0	0.0	0.0
3. Children 1 through 21 Years of Age	10,270	100.0	0.0	0.0	0.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	50	100.0	0.0	0.0	0.0	0.0
4. Others	365	100.0	0.0	0.0	0.0	0.0
Total	12,093					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	883	Yes	883	100.0	883	725
2. Infants < 1 Year of Age	881	Yes	881	100.0	881	733
3. Children 1 through 21 Years of Age	19,278	No	17,909	100.0	17,909	10,270
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,290	Yes	1,290	100.0	1,290	50
4. Others	28,297	Yes	28,297	26.0	7,357	365

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: This is the total number of pregnant women who had live births in 2020.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: These are total numbers of live births delivered in 2020.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: These are children who were either seen at the Community Health Centers.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Children with Special Health Care Needs who were served by only one Client Navigator.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Women who were served at women's clinics as well as travelers arriving and departing at seaport and airport who received a COVID-19 test.	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2020**
	Field Note: Total number of clients served by Title V.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: All pregnant women were served.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: All infants were served.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Total number of children 1 through 21 who were served by Title V across all levels of the pyramid.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Number of Children and Youth with Special Health Care Needs served by Title V across all levels of the pyramid.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Estimate percentage of Other population served during COVID-19 across all levels of the pyramid.	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: American Samoa

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	734	1	0	1	0	23	709	0	0
Title V Served	734	1	0	1	0	23	709	0	0
Eligible for Title XIX	734	1	0	1	0	23	709	0	0
2. Total Infants in State	734	1	0	1	0	23	709	0	0
Title V Served	734	1	0	1	0	23	709	0	0
Eligible for Title XIX	734	1	0	1	0	23	709	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: American Samoa

Toll-Free numbers are not available to all jurisdictions.

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number		
2. State MCH Toll-Free "Hotline" Name		
3. Name of Contact Person for State MCH "Hotline"		
4. Contact Person's Telephone Number		
5. Number of Calls Received on the State MCH "Hotline"		

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites	https://www.facebook.com/mchamericansamoa	https://www.facebook.com/mchamericansamoa
6. Number of Hits to the State Title V Program Social Media Websites		1,400

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: American Samoa

1. Title V Maternal and Child Health (MCH) Director	
Name	Anaise Uso
Title	MCH Program Manager
Address 1	PO Box 3378
Address 2	PO Box 3378
City/State/Zip	Pago Pago / AS / 96799
Telephone	(684) 633-4008
Extension	
Email	anaise@doh.as

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Ipuniuesea Eliapo
Title	Leo-O-Aiga Program Director
Address 1	PO Box 332
Address 2	
City/State/Zip	Pago Pago / AS / 96799
Telephone	(633) 684-4008
Extension	
Email	ieliapo@doh.as

3. State Family or Youth Leader (Optional)	
Name	Seinia Avapalu
Title	Leo-O-Aiga Program Manager
Address 1	PO Box 998292
Address 2	
City/State/Zip	Pago Pago / AS / 96799
Telephone	6846334008
Extension	
Email	avapalum@gmail.com

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: American Samoa

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.	Revised
2.	Establish a Newborn Metabolic Screening Program in American Samoa	New
3.	Families are empowered to make educated choices about infant health and well-being.	Revised
4.	Developmentally appropriate care and services are available for all children.	Revised
5.	Communities and providers support adolescents' physical, mental and emotional health.	Revised
6.	Improve System of Care for Children and Youth with Special Health Care Needs.	Continued
7.	Establish a Maternal and Child Health Centralized Database at the Department of Health.	New
8.	Reduce Rates of Rheumatic Heart Disease	Revised

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.	Revised
2.	Establish a Newborn Metabolic Screening Program in American Samoa	New
3.	Families are empowered to make educated choices about infant health and well-being.	Revised
4.	Developmentally appropriate care and services are available for all children.	Revised
5.	Communities and providers support adolescents' physical, mental and emotional health.	Revised
6.	Improve System of Care for Children and Youth with Special Health Care Needs.	Continued
7.	Establish a Maternal and Child Health Centralized Database at the Department of Health.	New
8.	Reduce Rates of Rheumatic Heart Disease	Revised

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: American Samoa

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	63.1 %	9.9 %	1,016	1,609

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	38.7
Numerator	284
Denominator	733
Data Source	SILAS
Data Source Year	2020

NOM 1 - Notes:

SILAS DATABASE is the Shared Integrated Linked American Samoa Database all birth records from Vital Statistics are entered, as well as database used by Helping Babies Hear Program, Helping Hands and MCH Title V.

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	437.8
Numerator	32
Denominator	731
Data Source	POSTPARTUM DATA
Data Source Year	2020

NOM 2 - Notes:

This Data is not available. This data made available next year, once all information are entered into SILAS from the Vital Statistics Records.

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

NOM 3 - Notes:

The Maternal Mortality Data is not available yet in SILAS. Per the Public Health Surveillance Office, this data should be available by December 2021 for 2020.

Data Alerts:

1.	Data has not been entered for NOM 3. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	5.2 %	0.7 %	53	1,012
2015	3.2 %	0.5 %	34	1,078
2014	4.5 %	0.6 %	49	1,077
2013	3.3 %	0.6 %	36	1,077
2012	5.2 %	0.7 %	61	1,163
2011	4.3 %	0.6 %	54	1,255
2010	3.7 %	0.5 %	46	1,234
2009	2.7 %	0.4 %	36	1,340

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	5.6 %	1.8 %	1,323	23,465

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	5.9
Numerator	43
Denominator	733
Data Source	SILAS DATABASE
Data Source Year	2020

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.7 %	2.2 %	2,753	23,465

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	4.8
Numerator	35
Denominator	733
Data Source	SILAS DATABASE
Data Source Year	2020

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	19.2
Numerator	141
Denominator	733
Data Source	SILAS DATABASE
Data Source Year	2020

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	733
Data Source	SILAS DATABASE
Data Source Year	2020

NOM 7 - Notes:

American Samoa LBJ Tropical Medical Center Authority does not endorse non-medically indicated early elective deliveries.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 7. Please review your data to ensure this is correct.

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2017	NR	NR	NR	NR
2016	13.8	3.7	14	1,018
2015	9.2	2.9	10	1,086
2014	14.7	3.7	16	1,087
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	5.4
Numerator	4
Denominator	735
Data Source	SILAS DATABASE
Data Source Year	2020

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2017	12.3 ϟ	3.6 ϟ	12 ϟ	977 ϟ
2016	13.8 ϟ	3.7 ϟ	14 ϟ	1,012 ϟ
2015	9.3 ϟ	3.0 ϟ	10 ϟ	1,078 ϟ
2014	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2013	9.3 ϟ	3.0 ϟ	10 ϟ	1,077 ϟ
2012	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2011	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2010	11.3 ϟ	3.1 ϟ	14 ϟ	1,234 ϟ
2009	11.2 ϟ	2.9 ϟ	15 ϟ	1,340 ϟ

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	6.8
Numerator	5
Denominator	733
Data Source	SILAS DATABSE
Data Source Year	2020

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	2.7
Numerator	2
Denominator	733
Data Source	SILAS DATABASE
Data Source Year	2020

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	4.1
Numerator	3
Denominator	733
Data Source	SILAS DATABASE
Data Source Year	2020

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

NOM 9.4 - Notes:

The Mortality Data is not available at this time. The Public Health Surveillance Office is in the process of entering all 2020 and 2021 Death Certificates into the SILAS Database at the same time. Tentative date for completion may be January 30, 2022.

Data Alerts:

1.	Data has not been entered for NOM 9.4. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Federally available Data (FAD) for this measure is not available/reportable.

NOM 10 - Notes:

Data not available in SILAS.

Data Alerts:

1.	Data has not been entered for NOM 10. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

NOM 11 - Notes:

DATA not available on SILAS.

Data Alerts:

1.	Data has not been entered for NOM 11. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.8 %	2.7 %	2,626	22,263

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	79.5
Numerator	757
Denominator	952
Data Source	BASIC SCREENING SURVEY
Data Source Year	2020

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	108.4	34.3	10	9,222

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
2008_2010	NR	NR	NR	NR
2007_2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
2008_2010	NR	NR	NR	NR
2007_2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	6.4 %	1.8 %	1,504	23,465

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0 % ϟ	0 ϟ	0 ϟ	1,504 ϟ

Legends:

ϟ Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	3.3
Numerator	50
Denominator	1,504
Data Source	CSHCN
Data Source Year	2020

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0 %	0	0	19,706

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0 %	0	0	19,706

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0 % ϟ	0 ϟ	0 ϟ	481 ϟ

Legends:

ϟ Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	69.6 %	5.0 %	16,322	23,465

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	14.0 %	0.7 %	363	2,590
2016	13.7 %	0.7 %	387	2,824
2014	16.3 %	0.7 %	514	3,160
2012	14.7 %	0.6 %	478	3,251
2010	14.6 %	0.6 %	470	3,221
2008	19.3 %	0.7 %	603	3,119

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	41.2 %	0.9 %	1,536	3,731
2011	38.9 %	0.9 %	1,470	3,776
2007	38.3 %	0.8 %	1,429	3,727

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS) - Age 10-17

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	24.9 %	4.5 %	2,574	10,319

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	93.4 %	1.9 %	21,927	23,465

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	44.1
Numerator	524
Denominator	1,188
Data Source	American Samoa Immunization Program (ASIP)
Data Source Year	2020

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	74.7
Numerator	21,790
Denominator	29,153
Data Source	American Samoa Immunization Program (ASIP)
Data Source Year	2020

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	93.9
Numerator	4,172
Denominator	4,443
Data Source	American Samoa Immunization Program (ASIP)
Data Source Year	2020

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	92.1
Numerator	4,092
Denominator	4,443
Data Source	American Samoa Immunization Program (ASIP)
Data Source Year	2020

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	93.2
Numerator	4,143
Denominator	4,447
Data Source	American Samoa Immunization Program (ASIP)
Data Source Year	2020

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2017	38.4	4.0	92	2,395
2016	40.8	4.1	99	2,425
2015	42.3	4.1	105	2,485
2014	46.0	4.2	118	2,565
2013	45.6	4.1	125	2,741
2012	44.1	3.9	129	2,922
2011	43.7	3.8	133	3,045
2010	38.6	3.5	119	3,080
2009	42.8	3.8	130	3,037

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	29.5
Numerator	66
Denominator	2,237
Data Source	SILAS
Data Source Year	2020

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Federally available Data (FAD) for this measure is not available/reportable.

NOM 24 - Notes:

DATA not available on SILAS

Data Alerts:

1.	Data has not been entered for NOM 24. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.6 %	1.1 %	621	23,465

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: American Samoa

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		48
Annual Indicator	47.0	47.0
Numerator	5,703	5,703
Denominator	12,140	12,140
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	0.1	0.2	9.7	9.9	48
Annual Indicator	9.4	9.5	27.5	35.4	27.7
Numerator	918	921	2,633	3,241	2,450
Denominator	9,720	9,720	9,561	9,147	8,847
Data Source	Postpartum Data	Postpartum Data	CHC UDS Report, US Census International Database	CHC UDS Report	CHC UDS Report
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.0	52.0	54.0	56.0	58.0	59.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Numerator: A total of 2633 unduplicated number of women, ages 18 through 44 had a preventive medical visit in the past year at the Community Health Center. Preventive medical visits range from screening (i.e. cervical cancer screening- pap smears etc.) counseling (weight management and diabetes, oral health and dental caries etc.), and immunizations (seasonal flu vaccine etc.)

Denominator: A total of 9561 women, ages 18 through 44 were estimated by the US Census International Database for American Samoa in 2018.

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	86.7	81.9
Annual Indicator	83.0	83.0
Numerator	6,253	6,253
Denominator	7,533	7,533
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	82	83	86	86.7	81.9
Annual Indicator	76	75.1	72	81	79.8
Numerator	753	701	630	665	580
Denominator	991	934	875	821	727
Data Source	ASWIC	ASWIC	ASWIC	ASWIC	ASWIC
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	82.0	82.5	83.0	83.5	84.0	85.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data reported from American Samoa WIC Office.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data reported from American Samoa WIC Office.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data reported from American Samoa WIC Office.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data reported from American Samoa WIC Office.	

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	20	21	43	43.5	12.5
Annual Indicator	9	8	13	12.1	8.1
Numerator	89	75	114	99	59
Denominator	991	934	875	821	727
Data Source	ASWIC	ASWIC	ASWIC	ASWIC	ASWIC
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.0	13.5	14.0	14.5	15.0	16.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data reported from American Samoa WIC Office.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data reported from American Samoa WIC Office.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator: A total of 407 infants who were breastfed exclusively through 6 months was reported by the Women Infant Children (WIC) Program of American Samoa for 2018 (January to December. Denominator: A total of 918 live births were reported by the MCH Postpartum and LBJ Nursery data which was confirmed by Electronic Health Records for 2018 (January to December).	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data reported from American Samoa WIC Office.	

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

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	10	5
Annual Indicator	0	0
Numerator	0	0
Denominator	2,859	2,859
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			5	10	5
Annual Indicator	2.9	3	1.3	5.3	7.1
Numerator	180	180	49	197	352
Denominator	6,256	6,028	3,861	3,724	4,939
Data Source	Part c and MEICHV	Part c and MEICHV	MCH CSHCN and Part C Helping Hands Early Intv.	MCH CSHCN and Part C Helping Hands Early Intv.	MCH CSHCN and Part C Helping Hands Early Intv.
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	6.0	7.0	8.0	9.0	10.0	11.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator: A total of unduplicated 49 children, ages 9 through 35 months, whose parents completed a Standardized Developmental Screening tool in the past year were reported by the MCH CSHCN Program (18 children ages 9 through 35 months) and Helping Hands (31 children ages 9 through 35 months). Denominator: A total of 3861 children, ages 0 through 3 years were estimated by the US Census International for American Samoa in 2018.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator: A total of 197 children, ages 9 through 35 months, whose parents completed a Standardized Developmental Screening tool in the past year were reported by the MCH CSHCN and Zika Program (172 children ages 9 through 35 months) and Helping Hands (25 children ages 9 through 35 months) Denominator: A total of 3724 children, ages 0 through 3 years were estimated by the US Census International for American Samoa in 2019.	

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	61	55
Annual Indicator	37.7	37.7
Numerator	2,923	2,923
Denominator	7,753	7,753
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			60	61	55
Annual Indicator	70.8	77	39.8	54.2	12.9
Numerator	4,561	5,049	2,555	3,321	687
Denominator	6,440	6,555	6,414	6,127	5,340
Data Source	AS CHC and Immunization Program	AS CHC and Immunization Program	Immunization Office Registry Web IZ US Census Int.	CHC UDS Report	CHC UDS Report
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	56.0	57.0	58.0	59.0	60.0	61.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Numerator: A total of 2555 unduplicated number of adolescents, ages 12 through 17, with a preventive medical visit in 2018 was reported by the Office of Immunization Registry System, Web Iz. Adolescent immunizations occurred at Well Baby Clinics, three of four clinics are housed at 3 health centers and one independent well baby clinic. In addition, an unduplicated number of adolescents, ages 12 through 17 who were vaccinated at immunization outreach programs are included.

Denominator: A total of 6414 adolescents, ages 12 through 17 was estimated by the US Census International Database for 2018 from January to December.

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective	72.5	73
Annual Indicator	0	0
Numerator	0	0
Denominator	1,504	1,504
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			72	72.5	73
Annual Indicator	71.8	74.3	43.3	60.6	33.3
Numerator	18,366	19,099	7,815	10,553	1,779
Denominator	25,579	25,722	18,063	17,418	5,340
Data Source	ASCHC and Immunization Program	ASCHC and Immunization Program	MCH CSHCN, Part C, CHC UDS Report	CHC UDS Report	CHC UDS Report
Data Source Year	2016	2016	2018	2019	2020
Provisional or Final ?	Final	Provisional	Final	Final	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	35.0	40.0	50.0	60.0	70.0	75.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Numerator: A total of 7815 children (135 children with special health care needs and 7680 children without special health care needs) ages 0 through 17, who met the criteria for having a medical home (personal doctor or nurse, usual source for care, and family-centered care; referrals or care coordination if needed) were reported by the following sources: MCH CSHCN (104 children ages 0-17y), Helping Hands Part C Early Intervention (31 children ages 0-3y) and the Community Health Center's Uniformed Data System (UDS) Report for 2018.

Denominator: The US Census International Database has estimated a total of 18063 children, ages 0 through 17 for American Samoa in 2018.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		
Annual Indicator	31.1	31.1
Numerator	6,934	6,934
Denominator	22,263	22,263
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data		
	2019	**2020**
Annual Objective		
Annual Indicator	43.6	4.7
Numerator	6,934	687
Denominator	15,918	14,546
Data Source	MCH Jurisdictional Survey	CHC UDS Report
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	32.0	33.0	34.0	35.0	36.0	37.0

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: American Samoa

SPM 1 - Percent of newborns receiving Blood Spot Screening

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	733
Data Source	SILAS
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	10.0	15.0	20.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percent of children ages 3 who have completed their age-appropriate routine vaccinations.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		4	51	51.2	51.5
Annual Indicator	51.3	40.1	42.5	40.5	32.8
Numerator	1,144	1,130	1,139	1,070	2,640
Denominator	2,230	2,820	2,680	2,643	8,049
Data Source	AS IP	ASIP	ASIP	ASIP	ASIP
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	52.0	53.0	54.0	65.0	65.0	66.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: This data was pulled by CDC from the WEBIZ database back in Back in July 2016, ASIP reported that 34% of children 19-35 months were up to date with their immunization (431334) in 2015. But with the introduction of the varicella vaccine, the up to date status was significantly affected (4313314) and hence the major drop in percentage.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator: A total of 1139 children age 3 who received 4:3:1:3(4):3:1:4 series of routine vaccinations was reported by the Office of Immunization Registry System, Web Iz in 2018 from January to December. Denominator: A total of 2680 children age 3 years in 2018 have been recorded in Web IZ	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator: A total of 1070 children age 3 who received 4:3:1:3(4):3:1:4 series of routine vaccinations was reported by the Office of Immunization Registry System, Web Iz in 2019 from January to December. Denominator: A total of 2643 children age 3 years in 2019 have been recorded in Web IZ	

SPM 3 - Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			29	30	31
Annual Indicator	34.8	43.6	15.1	9.4	0
Numerator	49	60	20	12	0
Denominator	14,071	13,749	13,248	12,768	11,286
Data Source	RHD registry 2016	RHD registry	MCH RHD Registry (BYU, OSHU, MCH)	MCH RHD Registry (BYU, OSHU, MCH)	MCH RHD Registry
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.0	31.0	30.0	14.1	12.0	0.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Numerator: A total of 20 new cases of Rheumatic Heart Disease was diagnosed by RHD Screening Programs in 2018 from January to December (BYU: 8 new RHD cases, OSHU: 9 new RHD cases, MCH: 3 new RHD cases)

Denominator: A total of 13248 children and adolescents ages 5-17 years have been estimated by the US Census International for 2018 from January to December.

SPM 4 - Maternal and Child Health Centralized Database System in SILAS

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	SILAS	SILAS
Data Source Year	2019	2020
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of Pregnant Women who tested Positive for Zika.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		20	19	18	17
Annual Indicator	2,360.6	431.3	0	0	0
Numerator	237	43	0	0	0
Denominator	1,004	997	931	814	727
Data Source	ASDOH Lab	ASDOH Lab	ASDOH Lab	ASDOH Lab	ASDOH Lab
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: This is the total number of pregnant women reported by DOH Laboratory were tested positive or Zika.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: This is the total number of pregnant women reported by DOH Laboratory were tested positive or Zika based on the Zika Cumulative Linelist.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator: According to the American Samoa Department of Health Surveillance, there were no women reported to be diagnosed with Zika during Pregnancy in 2018 from January to December. Denominator: A total of 931 occurrent births (both live and still births) were reported by the MCH Postpartum and LBJ Nursery data, confirmed by Electronic Health Records for 2018 from January to December.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This is the total number of pregnant women reported by DOH Laboratory were tested positive or Zika based on the Zika Cumulative Linelist.	

2016-2020: SPM 2 - Percent of children, ages 1 through 3 years, who had a preventive dental service in the past year.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			1	2	3
Annual Indicator	0.9	0.4	1.1	40.8	2.2
Numerator	29	14	44	1,144	54
Denominator	3,200	3,200	3,861	2,807	2,427
Data Source	CHC Dental Clinics	CHC Dental Clinics	CHC Dental Clinic	CHC Dental Clinic	CHC Dental Clinic
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Numerator: A total of 44 unduplicated children ages 1 through 3 were reported by the Dental Clinic of the Tafuna Community Health Centers with a preventive dental service in 2018 (Jan-Dec.)
Denominator: A total of 3861 children ages 1 through 3 years have been estimated by the US Census International Database for American Samoa in 2018.

2016-2020: SPM 5 - Percent of families of children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV who reports they are satisfied with their care coordination services.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			20	25
Annual Indicator			23.3	43.8
Numerator			58	109
Denominator			249	249
Data Source			Zika Registry	Zika Registry
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This was reported by families who were actively utilizing the care coordination services because they were satisfied with the services they recieve.

Form 10
State Outcome Measures (SOMs)

State: American Samoa

Form 10
State Outcome Measures (SOMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SOM 1 - RHD Mortality Rate for ages 5 - 17 years per 10,000.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective		29	30	0
Annual Indicator	28.9	0	0	0
Numerator	60	0	0	0
Denominator	20,789	13,248	12,297	11,286
Data Source	RHD Registry	Vital Statistics Death data, US Census Int.	Vital Statistics Death data, US Census Int.	SILAS
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Provisional	Provisional

Field Level Notes for Form 10 SOMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Numerator: According to the death data released by the Office of Vital Statistics, there were no reported deaths among children ages 5 through 17 years.

Denominator: The US Census International Database have estimated a total of 13248 children ages 5 through 17 years in American Samoa for 2018 from January to December.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
This is the same data source as previous years. The Public Health Surveillance Office now enters Vital Statistics into SILAS. This number is provisional until data is made available by January 30, 2022.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: American Samoa

ESM 1.1 - Percent of media outlets utilized to promote preventive medical visits.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			50	60	75.5
Annual Indicator	30	40	50	60	70
Numerator	3	4	5	6	7
Denominator	10	10	10	10	10
Data Source	DOH Media	DOH Media	DOH MCH Media	DOH MCH Media	DOH MCH Media
Data Source Year	2016	2016	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	76.0	77.0	78.0	79.0	80.0	81.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Numerator: A total of 5 media outlets were utilized to promote medical visits among women age 18 to 44 years in 2018, 4 local radio stations and 1 local TV station. Specifically, medical visits promoted were prenatal care offered at the Community Health Centers at no cost.

Denominator: There is a total 8 media outlets in American Samoa in 2018: 1 local newspaper, 4 local radio stations, 1 local TV station, 1 movie theater, and social media (Facebook).

ESM 1.2 - Percent of Providers receiving Technical Assistance Training in Prenatal Care Standards of Care and Provider Competencies.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	10	10
Data Source	CHC	CHC
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	40.0	60.0	80.0	90.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Percent of postpartum women, who received a depression screening after delivery.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	836	735
Data Source	CHC UDS	CHC UDS
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Postpartum screening is not yet implemented.

ESM 1.4 - Percent of pregnant women who receive at least one preventive dental service in the past year.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	1.4
Numerator	10
Denominator	725
Data Source	FQHC UDS
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	1.4	5.0	10.0	15.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.5 - Percentage of women who have completed recommended COVID-19 vaccination doses .

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0.5
Numerator	45
Denominator	8,847
Data Source	ASIP WEBIZ
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	80.0	81.0	82.0	83.0	84.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Percent of mothers initiated breastfeeding of their infants within 1 hour of birth.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	56.6
Numerator	415
Denominator	733
Data Source	SILAS
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	60.0	65.0	70.0	75.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Percentage of providers and health educators receiving breastfeeding TA training.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	10
Data Source	FQHC UDS REPORT
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	30.0	40.0	50.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.3 - Percentage of BF women who access the virtual chat room for lactation and peer counseling.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	838	725
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.4	3.0	5.0	10.0	20.0	30.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active
State Provided Data	
	2020
Annual Objective	
Annual Indicator	1.4
Numerator	10
Denominator	733
Data Source	MCH TITLE V
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	20.0	5.0	10.0	20.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.5 - Percentage of Breastfeeding Feeding Coalition Members who report they meet at least 6 times a year

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	10
Data Source	MCH TITLE V
Data Source Year	2020
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.6 - Percent of House and Senate who are aware of the importance of paid Maternity Leave.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	6.7
Numerator	0	2
Denominator	30	30
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	50.0	60.0	70.0	80.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - Percent of providers serving children and families participating in learning collaborative.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	20	20
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	60.0	70.0	80.0	90.0	95.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.2 - Percent of families who participated in community outreach activities hosted by MCH to promote developmental screenings.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	2.1	2.5
Numerator	57	60
Denominator	2,721	2,427
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	12.0	14.0	16.0	18.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Percent of adolescents who have a wellness check-up passport.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		0
Numerator		0
Denominator		6,197
Data Source		MCH TITLE V
Data Source Year		2020
Provisional or Final ?		Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	35.0	40.0	41.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.2 - Percent of children and adolescents enrolled in the Intersections Inc. Sexual Health Education and Ta'iala Peer Leaders had an annual medical check-up.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	51.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.3 - Percent of adolescents who have heard or read through mass media campaign the importance of an annual check-up.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	51.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	40.0	60.0	80.0	90.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - Percent of Providers attending Autism Screening Training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.3 - Percent of CSHCN families receive transition training.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	15.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - Percent of children 0-3 years receiving fluoride varnish at least twice a year.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	3.2	2.2
Numerator	90	53
Denominator	2,807	2,427
Data Source	MCH TITLE V	MCH TITLE V
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	5.0	10.0	20.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - Percent of women registered during Women's Health Week for preventive screenings.

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			35
Annual Indicator			1.3
Numerator			119
Denominator			8,847
Data Source			FQHC UDS DATA
Data Source Year			2020
Provisional or Final ?			Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 1.3 - Percent of Pregnant Women who has heard of the “Fight the Bite” Zika Campaign

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			1
Annual Indicator			0
Numerator			0
Denominator			725
Data Source			FQHC UDS
Data Source Year			2020
Provisional or Final ?			Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.1 - Number of MCH staff attended the Certified Lactation Counselor training.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			19	20	21
Annual Indicator	0	18.2	0	0	0
Numerator	0	2	0	0	0
Denominator	13	11	13	15	13
Data Source	ASMCH	ASMCH	AS MCH	AS MCH	AS MCH
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Numerator: In 2018, there were no MCH Staff who attended the Certified Lactation Counselor training.
Denominator: There was total of 13 MCH Staff in 2018.

2016-2020: ESM 4.2 - Percent of women participating at the Breastfeeding Week activities who confirm they are breastfeeding.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		49	14	14.1	14.5
Annual Indicator	14.4	13.2	23.8	19.5	19.3
Numerator	110	113	134	140	23
Denominator	765	856	562	718	119
Data Source	MCH TITLE V	MCH TITLE V	MCH TITLE V	MCH TITLE V	MCH TITLE V
Data Source Year	2015	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator: A total of 134 women participated in the 2018 Breastfeeding Week Celebration according to the WIC program list and MCH Health educator list. Denominator: A total of 562 postpartum women was confirmed by the MCH Postpartum and LBJ Nursery data confirmed by Electronic Health Records. The 562 postpartum women gave birth from January 1 to July 31 2018.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator: MCH did not conduct any breastfeeding activities in 2019 due to the DOH COVID19 response of repatriated citizens. Denominator: 718 mothers who gave birth in 2019 attempted to breastfeed their baby.	

2016-2020: ESM 4.3 - Percent of postpartum mothers reported that they received breastfeeding resources and reminders after delivery and before discharge.

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			60
Annual Indicator			92.1
Numerator			675
Denominator			733
Data Source			SILAS
Data Source Year			2020
Provisional or Final ?			Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.1 - Number of Providers utilizing a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		51	40	50	60
Annual Indicator	20	30	27.3	18.2	9.1
Numerator	2	3	3	2	1
Denominator	10	10	11	11	11
Data Source	CHC Data	CHC Data	CHC UDS	CHC UDS	CHC UDS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Medical Staff were introduced to examples of evidence-based Developmental Screening Tools and their significance in identifying children who need early intervention services in a timely manner. This CME training was done by Dr. Louise Iwaichi, Director of LEND Program in Hawaii and Chief of Pediatrics in Queens Medical Center.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator: A total of 3 providers utilize a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months in 2018. Denominator: There is a total of 11 providers in the Community Health Center in 2018.	

2016-2020: ESM 6.2 - Percent of clinical staff trained in the standing operating procedures for referrals to Early intervention and other programs.

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			50
Annual Indicator			0
Numerator			0
Denominator			10
Data Source			MCH TITLE V
Data Source Year			MCH TITLE
Provisional or Final ?			Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.3 - Percent of participants in Children's Oral Health awareness month activities.

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			10
Annual Indicator			0
Numerator			0
Denominator			2,427
Data Source			FQHC UDS
Data Source Year			2020
Provisional or Final ?			Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 10.1 - Percent of schools covered by Immunization School Outreach Program.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	79	80	81
Annual Indicator	54.8	78.6	95.6	100	100
Numerator	23	33	43	45	45
Denominator	42	42	45	45	45
Data Source	ASIP	ASIP	ASIP	ASIP	ASIP
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:

Numerator: There was a total of 43 elementary and high schools that were covered by Immunization School Outreach Program in 2018 according to Office of Immunization Records and the MCH Epidemiologist who collected the data for the territory wide vaccine campaign in December 2018.

Denominator: According to the AS Department of Education list, there are 23 public elementary schools and 6 public high schools, in addition to 10 private elementary schools and 6 private high schools. Therefore the total number of elementary and high schools in AS is 45 schools.

2016-2020: ESM 10.2 - Number of high schools covered by Immunization School Outreach Program.

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			95
Annual Indicator	27.3	90.9	100
Numerator	3	10	11
Denominator	11	11	11
Data Source	ASIP	ASIP	ASIP
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The immunization program was only able to go to several schools for outreach programs. This is specifically due to the schools requesting for outreach.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Several immunization campaigns occurred in 2019. Beginning of the year was the MCV, HPV and Tdap immunization campaign due to MCV outbreak scare in New Zealand. On Nov 16, 2019, American Samoa declared a measles outbreak and therefore immunization for school children was enforced.	

2016-2020: ESM 11.1 - Percent of CSHCN families who received care coordination services from CSHCN staff in the past year.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		15	59	60	61
Annual Indicator	80	58.2	48.6	42.3	48.1
Numerator	88	64	51	44	50
Denominator	110	110	105	104	104
Data Source	2016	2017	2018	2019	2020
Data Source Year	CSHCN	CSHCN	CSHCN	CSHCN	CSHCN
Provisional or Final ?	Provisional	Provisional	Final	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Numerator: A total of 51 CSHCN (Age 1-21 years) received care coordination from CSHCN staff in 2018.
Denominator: There is a total of 105 CSHCN clients for the MCH CSHCN Program as of December 2018.

Form 10
State Performance Measure (SPM) Detail Sheets

State: American Samoa

SPM 1 - Percent of newborns receiving Blood Spot Screening
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Establish a Newborn Bloodspot Screening Program in American Samoa.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of infants who receive a blood spot screen at birth.</td></tr>
<tr><td>Denominator:</td><td>Total number of live births.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>SILAS</td></tr>
<tr><td>Significance:</td><td>Newborn bloodspot screening (NBS or heel prick test) can identify the small number of babies that have rare, but serious medical conditions. These conditions can’t be seen just by looking at the baby. Early diagnosis and treatment can save lives.</td></tr>
</table>

SPM 2 - Percent of children ages 3 who have completed their age-appropriate routine vaccinations.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase number of children ages 3 years of age who received the 4:3:1:3(4):3:1:4 series of routine vaccinations.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of children ages 3 who received 4:3:1:3(4):3:1:4 series of routine vaccinations. **Denominator:** Total number of children ages 3 years.
Data Sources and Data Issues:	AS Immunization Program
Significance:	There is still a need to boost the number of kids completing their shots on time prior to school enrollment at Head Start in American Samoa. People in the United States continue to get diseases that are vaccine preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death in the United States and account for substantial spending on the related consequences of infection. Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule (this includes DTap, Td, Hib, Polio, MMR, Hep B, and varicella vaccines), society: Saves 33,000 lives. Prevents 14 million cases of disease. Reduces direct health care costs by $9.9 billion. Saves $33.4 billion in indirect costs. Despite progress, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases.* Communities with pockets of unvaccinated and undervaccinated populations are at increased risk for outbreaks of vaccine-preventable diseases. In 2008, imported measles resulted in 140 reported cases—nearly a 3-fold increase over the previous year. The emergence of new or replacement strains of vaccine-preventable disease can result in a significant increase in serious illnesses and death.

SPM 3 - Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease. Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	To reduce the rate of children and adolescents diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.
Definition:	**Unit Type:** Rate **Unit Number:** 10,000 **Numerator:** (A) Number of new cases of Rheumatic Fever (B) Number of new cases of Rheumatic Heart Disease. **Denominator:** Total number of children and adolescents ages 5-17 years.
Data Sources and Data Issues:	RHD Registry
Significance:	Child and Adolescent Deaths from RHD are considered avoidable but in American Samoa its attributed to lack of preventive health care or timely and effective medical care. In the last 4-6 years, About five deaths were due to Rheumatic Heart Disease. Although, RHD is no longer reported in the US as significant causes of death among children, Rheumatic Fever and RHD is common in American Samoa still. This measure is included so that risk factors are addressed , or treating conditions (Strep throat) once they have occurred in order to prevent RF and or RF from developing into RHD.

SPM 4 - Maternal and Child Health Centralized Database System in SILAS
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Provide partnership and on-site support for the development and implementation of the Maternal and Child Health Centralized Database System (SILAS) that will enable tracking of all MCH Title V Data Needs (NPM, SPM, NOM, SOM).
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Is the MCH Database up and running in SILAS? **Denominator:**
Data Sources and Data Issues:	SILAS
Significance:	The primary purpose of this effort is to develop, enhance, and expand American Samoa's Title V Maternal and Child Health data capacity for its needs assessment and performance measure reporting in the Title V MCH Block Grant program. Such enhanced MCH data capacity will also assist American Samoa at the territorial and community level to engage in informed decision-making and resource allocation that supports effective, efficient and quality programming for women, infants, children and youth, including children and youth with special health care needs. This goal complements the Title V MCH Block Grant program by improving the availability, timeliness, and quality of MCH data. Utilization of these data is central to American Samoa's reporting on its Title V MCH Block Grant program assessment, planning, implementation, and evaluation efforts, along with related investments, in the yearly Title V MCH Block Grant application/annual report as well as the SSDI annual report. Other partners who will also benefit from this effort, includes MIECHV, Helping Babies Hear Program (EDHI), Helping Hands (Part C Early Intervention), FQHCs, SPED, Early and Head Start Programs, WIC and Medicaid Office.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of Pregnant Women who tested Positive for Zika.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce the number of Pregnant Women infected with Zika.
Definition:	**Unit Type:** Rate **Unit Number:** 10,000 **Numerator:** Number of Women diagnosed with Zika during Pregnancy. **Denominator:** Total number of Pregnant in the past year.
Healthy People 2020 Objective:	Maternal, Infant and Child Health Objective 6: Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery).
Data Sources and Data Issues:	Public Health Surveillance Zika Registry.
Significance:	Zika Viral Infection during pregnancy can lead to microcephaly and other related neurological problems in infants. Establishing a state-level pregnancy registry reporting system to actively monitor pregnant women with suspected or confirmed Zika infection is the first step to monitoring and surveillance. Other strategies recommended by CDC to promote and reduce the number of pregnant women infected by Zika include: (1) Training healthcare providers who are counseling patients on how to reduce their risk of sexual transmission of the Zika virus and reduce unintended pregnancies through provision of effective contraception. (2)Advise patients, especially pregnant women and women trying to become pregnant, on how to reduce mosquito exposure. (3) Ensure obstetric providers increase screening for symptoms of Zika and adhere to the CDC guidelines for monitoring pregnant women in regions with local transmission. American Samoa is currently considered one of the US Territories with local transmission.

2016-2020: SPM 2 - Percent of children, ages 1 through 3 years, who had a preventive dental service in the past year.
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of children ages 1 through 3 years who had a preventive dental service in the past year.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children, ages 1 through 3, who had a preventive dental service in the past year.</td></tr>
<tr><td>Denominator:</td><td>Total number of children ages 1 through 3 years.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>Related to Oral Health (OH) Objective 8. Increase the proportion of low-income children and adolescents who receive any preventive dental service during the past year. (Baseline: 30.2%, Target: 33.2%)</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>This is an integrated measure with two data sources:
A) Community Health Center UDS report.
B) National Survey of Children's Health (NSCH) once its available.</td></tr>
<tr><td>Significance:</td><td>American Samoa MCH TItle V and its key partners recognizes that oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</td></tr>
</table>

2016-2020: SPM 5 - Percent of families of children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV who reports they are satisfied with their care coordination services.
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To improve care coordination for families and children with Congenital Zika or born to pregnant women diagnosed with Zika.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of families of infants and children who are residing in American Samoa born with congenital Zika or to pregnant women with Zika, reports they are satisfied with their care coordination services.</td></tr>
<tr><td>Denominator:</td><td>Total number of families of infants and children residing in American Samoa born with congenital Zika or to pregnant women with Zika.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>Related to Maternal, Infant, and Child Health (MICH) Objectives 30.1: Increase the proportion of children who have access to a medical home, (Baseline: 57.5%, Target: 63.3%) and 30.2: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%)
Related to Objective Maternal, Infant, and Child Health (MICH) Objective 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems. (Baseline: 20.4% for children aged 0-11, Target: 22.4%; Baseline: 13.8% for children aged 12 through 17, Target 15.2%)</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>National Survey of Children's Health (NSCH) once available or MCH Title V survey.</td></tr>
<tr><td>Significance:</td><td>The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child’s family and a competent health professional familiar with the child and family and the child’s health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: American Samoa

Form 10
State Outcome Measure (SOM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SOM 1 - RHD Mortality Rate for ages 5 - 17 years per 10,000.
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Decrease child and adolescent mortality rate ages 5 - 17 years due to RHD.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Rate</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>Number of deaths among children ages 5 through 17 years.</td></tr>
<tr><td>Denominator:</td><td>Total number of children ages 5 through 17 years.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>RHD and RF is unique to American Samoa and other Pacific Islands. By addressing this measure we hope to reduce Child and Adolescent Mortality rates in the future due to RHD. The related HP2020 would be for children mortality rates. Between 2007 and 2013, deaths of children, adolescents, and young adults per 100,000 population declined: aged 5–9 years (MICH-3.2) from 13.8 to 11.8; for adolescents aged 10–14 (MICH-4.1) from 16.5 to 14.1; for adolescents aged 15–19 (MICH-4.2) from 60.3 to 44.8; and for young adults aged 20–24 (MICH-4.3) from 98.1 to 83.4, exceeding their respective 2020 targets. This may not be the case in American Samoa.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>LBJ Data & RHD Registry</td></tr>
<tr><td>Significance:</td><td>American Samoa is depicted as one of the highest rates of prevalence among children with Rheumatic Fever and/or Rheumatic Heart Disease. Rheumatic Heart Disease and Rheumatic Fever is highly prevalent in American Samoa due to many factors, some of which include environmental conditions and primary care prevention services. This cardiovascular disease greatly affects the overall health and outlook of children once diagnosed, not to mention the increased burden on the healthcare system of the Territory.

Child and Adolescent Deaths from RHD are considered avoidable but in American Samoa its attributed to lack of preventive health care or timely and effective medical care. In the last 4-6 years, About five deaths were due to Rheumatic Heart Disease. Although, RHD is no longer reported in the US as significant causes of death among children, Rheumatic Fever and RHD is common in American Samoa still. This measure is included so that risk factors are addressed , or treating conditions (Strep throat) once they have occurred in order to prevent RF and or RF from developing into RHD.</td></tr>
</table>

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: American Samoa

ESM 1.1 - Percent of media outlets utilized to promote preventive medical visits.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase number of women ages 21 - 44 utilizing available preventive medical visits.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of media outlets utilized to promote medical visits. **Denominator:** Total number of media outlets.
Data Sources and Data Issues:	ASMCH Title V
Significance:	Preconception health and other maternal diseases and risks/complications in future pregnancies and births can be addressed at medical preventive visits. This can help ensure that women receive adequate preventive health care and minimize complex problems that may derive from chronic illness or other risks factors that may lead to unfavorable conditions during pregnancies such as Gestational Diabetes. Women who are healthy prior to pregnancy usually have better pregnancy and birth outcomes than those who are not. There are ten media outlets in total: - 5 radio local stations - 3 TV stations for advertisements - Movie Theater - Local newspaper

ESM 1.2 - Percent of Providers receiving Technical Assistance Training in Prenatal Care Standards of Care and Provider Competencies.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Improve Prenatal Care Standards of Care and Provider Competencies.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Providers Receiving Technical Assistance Training in Prenatal Care Standards of Care and Provider Competencies. **Denominator:** Total number of providers serving women.
Data Sources and Data Issues:	MCH Title V
Significance:	Having the opportunity for medical providers to identify quality improvement projects in terms of standards of care and provider competencies are critical for improved patient care and utilization of services.

ESM 1.3 - Percent of postpartum women, who received a depression screening after delivery.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase women receiving a postpartum depression screening by 2%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Postpartum Women who received a Depression Screening **Denominator:** Total number of women giving live births in the reporting year.
Data Sources and Data Issues:	SILAS
Significance:	Perinatal depression, which includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery, is one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven women. It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects. Several screening instruments have been validated for use during pregnancy and the postpartum period. The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. It is recommended that all obstetrician–gynecologists and other obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient. If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum visit. There is evidence that screening alone can have clinical benefits, although initiation of treatment or referral to mental health care providers offers maximum benefit. Therefore, clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both. Interaction with the woman's obstetric provider ends shortly after the baby's birth. However, interactions with the pediatrician can be beneficial to providing screening while mother waits for baby's check-up.

ESM 1.4 - Percent of pregnant women who receive at least one preventive dental service in the past year.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Ensure all pregnant women coming in for their first visit get referred for a dental screening.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of pregnant women with a live birth who received a dental preventive visit prior to delivery. **Denominator:** Total number for pregnant women with a live birth.
Data Sources and Data Issues:	AS FQHC UDS DATA
Evidence-based/informed strategy:	Studies indicate that the most promising evidence-based strategies include (1) educating pregnant women, prenatal providers and students, and community-based program staff about perinatal and infant oral health; (2) integrating oral health and primary care practice; (3) ensuring a competent and adequate dental workforce; (4) ensuring comprehensive Medicaid dental coverage for women during pregnancy through 1 year postpartum and adequate reimbursement rates for dental services; (5) collecting and analyzing data on oral health among pregnant women at national, state, local, and program levels; and (6) conducting research to determine effective strategies and best practices to improve access to dental care among pregnant women. Integrating oral health and primary care practice is an important strategy for reducing oral health disparities and improving the oral and overall health of pregnant women. Primary care providers often have more frequent contact than dental providers with patients at the highest risk for oral diseases. It is estimated that each year there are 108 million Americans who see a physician but do not see a dentist.[46] In 2014, the Health Resources and Services Administration (HRSA) released Integration of Oral Health and Primary Care Practice, which includes a starter set of interprofessional oral health core clinical domains and competencies to facilitate change in the clinical practice of primary care providers working in the safety net community. The domains include risk assessment, oral health evaluation, preventive intervention (e.g., fluoride varnish applications), communication and education, and interprofessional collaborative practice (e.g., dental referrals). HRSA recommends that, for maximum impact, the core clinical competencies be incorporated into existing accreditation and certification standards to facilitate adoption in primary care education and practice. APHA recommends that community-based programs (e.g., WIC, EHS, and home visi
Significance:	Oral health is integral to overall health and a healthy pregnancy. Periodontal disease (gum disease) during pregnancy increases the risk for delivering a preterm and/or low birth weight infant. Only 46% of U.S. women have an oral prophylaxis (dental cleaning) during pregnancy. Routine prophylaxes reduce the potential for periodontal disease. In addition, children of mothers with untreated dental caries (tooth decay) are at high risk for developing tooth decay, the most prevalent chronic disease among U.S. children. Dental care during pregnancy is safe, important, and recommended by multiple health organizations. Improving

access to dental care during pregnancy requires many actions. Prenatal and dental students and providers, community-based program staff, and pregnant women should be educated about the safety and importance of dental care during pregnancy and where care can be obtained. Pregnant women should be educated about the importance of consuming fluoridated water to prevent tooth decay. Prenatal providers and community programs should integrate oral health education into visits with pregnant women and collect and report oral health data. Medicaid programs should include comprehensive dental benefits for women during pregnancy and 1 year postpartum. Medicaid reimbursement rates should be increased to attract more dental providers. Increased funding for public health programs and research focused on improving perinatal and infant oral health is essential. These strategies have the potential to significantly improve access to dental care, thus improving the oral and overall health of pregnant women and their children.

ESM 1.5 - Percentage of women who have completed recommended COVID-19 vaccination doses .
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the percentage of women who has completed recommended COVDI-19 vaccine doses.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women ages 18 - 44 years who completed the recommended doses of COVID-19 vaccine. **Denominator:** Total number of women ages 18 - 44 years of age.
Data Sources and Data Issues:	WEBIZ
Evidence-based/informed strategy:	COVID-19 vaccines are effective at protecting individuals from COVID-19, especially severe illness and death. COVID-19 vaccines reduce the risk of people spreading the virus that causes COVID-19. Individuals who are fully vaccinated, can resume activities they normally did before the pandemic. Studies show that COVID-19 vaccines are effective at preventing COVID-19. Getting a COVID-19 vaccine will also help prevent individuals from getting seriously ill even if they do get COVID-19. COVID-19 vaccines teaches immune systems how to recognize and fight the virus that causes COVID-19. It typically takes 2 weeks after vaccination for the body to build protection (immunity) against the virus that causes COVID-19. That means it is possible a person could still get COVID-19 before or just after vaccination and then get sick because the vaccine did not have enough time to build protection. People are considered fully vaccinated 2 weeks after their second dose of the Pfizer-BioNTech or Moderna COVID-19 vaccines, or 2 weeks after the single-dose Johnson & Johnson's Janssen COVID-19 vaccine. CDC is now recommending those with moderately to severely compromised immune systems should receive an additional dose of mRNA COVID-19 vaccine after the initial 2 doses.
Significance:	The highly transmissible B.1.617.2 (Delta) variant continues to spread across the United States at a rapid pace. Early data suggest that B.1.617.2 now makes up more than 50% of COVID-19 cases. In some parts of the country, this percentage is even higher, especially in areas with low vaccination rates. This rapid rise is concerning and threatens the progress the United States has made toward ending the pandemic. We have seen the success of the U.S. vaccination program over the last 8 months. As of July 8, 2021, 183.2 million people have received at least one dose of a COVID-19 vaccine, and 158.3 million are fully vaccinated.* However, we are also seeing new and emerging trends that are concerning. Cases and hospitalizations are on the rise in areas with low vaccination coverage. Data from recent weeks show that adults ages 18–49 now account for more than 40% of COVID-19-associated hospitalizations. Fortunately, we have safe and effective vaccines that prevent severe disease, hospitalization, and death. People who are fully vaccinated are protected from B.1.617.2. If

you are not yet vaccinated, you are at risk of infection and should continue to practice prevention strategies and get vaccinated as soon as possible. Turning the corner on the pandemic, getting back to normal, and stopping the spread of B.1.617.2 requires all of us doing our part.

ESM 4.1 - Percent of mothers initiated breastfeeding of their infants within 1 hour of birth.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve the rate of breastfeeding by encouraging mothers to breastfeed within the first hour of birth.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of infants are breastfed within first hour of birth.</td></tr>
<tr><td>Denominator:</td><td>Total number of live births.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>SILAS and Postpartum Data</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>In the United States, most mothers want – and try – to breastfeed. Unfortunately, one mother’s interest alone is not always enough to make breastfeeding possible. Rates of breastfeeding in the United States vary widely because of the multiple and complex barriers mothers face when starting and continuing to breastfeed.

Breastfeeding is linked to a reduced risk for many illnesses in children and mothers. National guidelines recommend exclusive breastfeeding for the first 6 months of life and continued breastfeeding for at least the first year. Although breastfeeding initiation rates are high in the United States, most women don’t breastfeed for the entire first year. Strategies like peer support, education, longer maternity leaves, and breastfeeding support in the hospital, workplace, and community may help more women breastfeed longer.

Breastfeeding in the first hour of life is associated with prolonged duration of breastfeeding and reduction of infant mortality, especially in low-income countries. The positive effects of breastfeeding on the newborn’s health can be attributed to the components of breast milk, as well as the contact between mother and baby. The colostrum, milk on its first days, contains the epidermal growth factor, which accelerates the development of the intestinal mucus, as well as the immunological bioactive factors that provide immunological protection to the newborns, preventing intestinal colonization by pathogenic microorganisms.

The “skin to skin” contact between mother and newborn immediately after birth favors the newborn’s skin colonization by the mother’s microbiota, facilitates the regulation of body temperature, maintains the blood glucose levels stable, and contributes to cardiorespiratory stability. The suction of the nipple right after birth stimulates the secretion of prolactin and oxytocin, hormones that induce the production and ejection of milk. The oxytocin also reduces puerperal bleeding and accelerates uterine involuti</td></tr>
<tr><td>Significance:</td><td>One of the most highly effective preventive measures a mother can take to protect the health of her infant and herself is to breastfeed. However, in the U.S., while 75 percent of mothers start out breastfeeding, only 13 percent of babies are exclusively breastfed at the end of six months. Additionally, rates are significantly lower for African-American infants.

Breast milk provides all of the nutrients an infant needs for the first six months. Additionally, it</td></tr>
</table>

has immunological properties that protect infants against common diseases, such as diarrhea and pneumonia, which are important causes of infant morbidity and mortality. Breastfeeding also presents advantages to the mother's health, increasing the postpartum infertility period, helping them return to their pregestational weight, and reducing their risk of developing breast 6 and ovarian cancer.

Despite the benefits of breastfeeding, the decision to breastfeed is a personal one, and a mother should not be made to feel guilty if she cannot or chooses not to breastfeed. The success rate among mothers who want to breastfeed can be greatly improved through active support from their families, friends, communities, clinicians, health care leaders, employers and policymakers.

Given the importance of breastfeeding for the health and well-being of mothers and children, it is critical that we take action across the country to support breastfeeding.

ESM 4.2 - Percentage of providers and health educators receiving breastfeeding TA training.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of trainers to promote exclusive breastfeeding.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Percent of infants who are breastfed. **Denominator:** Percent of infants who exclusively breastfed.
Data Sources and Data Issues:	SILAS
Evidence-based/informed strategy:	The USDA WIC has launched a national initiative to institutionalize peer counseling as a core service. American Samoa provides successful peer counseling programs, and the rest are implementing new programs as part of this national effort. After being given extensive training, peer counselors work primarily from home to provide telephone support to pregnant and breastfeeding mothers. In many programs, peer counselors also provide clinic-based counseling, make home visits during the early postpartum period, lead prenatal breastfeeding classes and postpartum support groups, and provide one-to-one support in the hospital setting.
Significance:	The goal of peer support is to encourage and support pregnant women and those who currently breastfeed. Peer support, which is provided by mothers who are currently breastfeeding or who have done so in the past, includes individual counseling and mother-to-mother support groups. Women who provide peer support undergo specific training and may work in an informal group or one-to-one through telephone calls or visits in the home, clinic, or hospital. Peer support includes psychoemotional support, encouragement, education about breast- feeding, and help with solving problems.

ESM 4.3 - Percentage of BF women who access the virtual chat room for lactation and peer counseling.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>1. Increase percentage of breastfeeding mothers by 5% in 2024.
2. Increase by 5%, 6 months infants who exclusively breastfeed in 2024.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Breastfeeding Coalition meetings within the reporting year.</td></tr>
<tr><td>Denominator:</td><td>Total number of meetings planned by Breastfeeding Coalition to include strategic planning and technical assistance trainings.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MCH Title V</td></tr>
<tr><td>Significance:</td><td>Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her childs nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and postnatal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.

Revamping the Breastfeeding Coalition to strategically plan upcoming technical assistant trainings and supporting medical staff in driving the Baby Friendly Initiatives are critical to meeting these goals.</td></tr>
</table>

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
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of women to breastfeed.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Percent of infants who are ever breastfed **Denominator:** Total number of women that gave birth.
Data Sources and Data Issues:	SILAS
Evidence-based/informed strategy:	SILAS
Significance:	Percent of infants who are ever breastfed

ESM 4.5 - Percentage of Breastfeeding Feeding Coalition Members who report they meet at least 6 times a year NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Support the coalition in seeking ways to reach clients on the importance of breastfeeding.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Participation of coalition members in the community. **Denominator:** Percentage of infant exclusively breastfed in the last 6 Months.
Data Sources and Data Issues:	SILAS
Evidence-based/informed strategy:	Breastfeeding is linked to a reduced risk for many illnesses in children and mothers. Exclusive breastfeeding for the first 6 months of life is linked to health benefits for infants
Significance:	. Although breastfeeding initiation rates are high in the United States, most women don't breastfeed exclusively for the first 6 months. Strategies like peer support, education, longer maternity leaves, and breastfeeding support in the hospital, workplace, and community may help more women breastfeed exclusively.

ESM 4.6 - Percent of House and Senate who are aware of the importance of paid Maternity Leave.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve the rates of breastfeeding working moms by promoting paid maternity leave to law makers.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Policy Makers who is aware of the importance of paid maternity leave.</td></tr>
<tr><td>Denominator:</td><td>Total number of Policy Makers to include House Representatives and Senate.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MCH Title V</td></tr>
<tr><td>Significance:</td><td>New mothers who are entitled to paid maternity leave beyond a few weeks’ duration are more likely to have better mental and physical health. In turn, their offspring have a slightly reduced likelihood of infant death and an increased chance of secure maternal attachment, breastfeeding and keeping up to date with vaccinations, according to a multi-institution study co-authored by UC San Francisco researchers.

While the United States offers qualifying parents up to 12 weeks of unpaid leave after a birth or adoption, just 16 percent of private industry employees have access to paid leave, according to the study, which publishes in Harvard Review of Psychiatry on March 9, 2020. More contentiously, close to one in four new mothers who are not eligible for paid leave return to work within 10 days of giving birth.

In contrast, nations like the United Kingdom and Mexico offer 12 weeks’ paid leave, versus 36 weeks in Japan and up to 85 weeks in Estonia, said senior author Christina Mangurian, MD, MAS, of the UCSF Department of Psychiatry and the UCSF Weill Institute for Neurosciences.

In their review, researchers evaluated 26 national and international studies that examined the impact of paid maternity leave and duration of leave. Among their findings:

A 2000 study from nine Western European countries showed that adding 10 weeks of paid maternity leave to the average paid leave in each country was linked to an approximate 5 percent drop in the number of infant deaths.
A 2012 U.S. study of 3,350 mothers showed that less than eight weeks of paid maternity leave was linked to poorer health and increased depression.
A 2011 Australian study of 1,507 mothers showed that women who took paid maternity leave were subject to 58 percent lower incidence of emotional and physical violence from their partners.
A 2005 study of 1,907 U.S. mothers found that those who had more than 12 weeks of paid maternity leave were more likely to have infants who were up to date on their vaccinations</td></tr>
</table>

ESM 6.1 - Percent of providers serving children and families participating in learning collaborative.
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase providers' competencies by establishing a learning collaborative that develops a strong family/professional partnerships by Implementing a quality improvement learning collaborative to improve developmental screening practices (e.g. t</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of providers who report they utilize their training in improving family/professional partnerships to improve developmental screenings.</td></tr>
<tr><td>Denominator:</td><td>Total number of providers who serve children up to 35 months.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>UDS</td></tr>
<tr><td>Significance:</td><td>There is strong evidence that interventions during pregnancy and early childhood have some of the greatest impacts on children’s lifelong health and development. Although parents’ knowledge and practices greatly affect their children’s healthy development, parenting education is lacking at the population level. A national study of new parents found that information was cited as one of their greatest needs. In a California study, the majority of parents (including 70% of Spanish-speaking parents) believed they did not have adequate knowledge to care for their young children. It has been difficult to reach parents who face barriers of literacy, language, poverty or disability with easy-to-use and engaging information.
The First 5 Kit for New Parents is an innovative, evidence- based approach to reach new parents with information about parenting practices and community resources. The “Kit” is a low-cost, multi-media collection of information for parents of children 0-5 years and their providers. It includes DVDs (featuring celebrities, experts and diverse parents), and printed materials that were written to be widely accessible to parents, including those with limited literacy, and those who speak Spanish, Cantonese, Mandarin, Vietnamese, Korean or English. Since 2001, the Kit has been distributed free of charge to 500,000 California parents each year through diverse perinatal and childcare programs. The Kit model was evaluated in a 3-year longitudinal survey of intervention and comparison groups of English- and Spanish-speaking parents and providers. Findings showed high Kit usage (87%) and satisfaction (94%). Parents in the intervention group showed significantly greater knowledge gains and reported better practices than parents in the comparison group. Providers considered the Kit a valuable resource to incorporate into their educational programs. The Kit model has now been adapted and extended to four other states and has reached over five million families.</td></tr>
</table>

ESM 6.2 - Percent of families who participated in community outreach activities hosted by MCH to promote developmental screenings.
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

Measure Status:	Active
Goal:	Implement 4 community outreach activities by September 30, 2022 to promote developmental screenings for .
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families of children ages 0 -35 months who participated in community outreach activities. **Denominator:** Total number of children ages 0 to 35 months.
Data Sources and Data Issues:	SILAS
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit. Early detection and referral to Helping Hands Early Intervention Program is critical for it helps children improve their abilities and learn new skills. Timely provision of developmental services can improve outcomes for children 0 to 3 years old with developmental delays.

ESM 10.1 - Percent of adolescents who have a wellness check-up passport.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of adolescents ages 10 - 17 years receiving a well-visit by 2% annually, for the next five years.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of adolescents ages 10 - 17 years with a wellness check-up passport.</td></tr>
<tr><td>Denominator:</td><td>Total number of adolescents 10 - 17 years I the reporting year.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>UDS</td></tr>
<tr><td>Significance:</td><td>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs.

Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults.

The Bright Futures guidelines recommend that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health, related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.

Establishing an adolescent well-visit passport to include weight management, reproductive health and behavioral health screening and counseling, based on Bright Futures.</td></tr>
</table>

ESM 10.2 - Percent of children and adolescents enrolled in the Intersections Inc. Sexual Health Education and Ta'iala Peer Leaders had an annual medical check-up.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To enrolled at least 50% of the participants in Sexual Health Education by June 30, 2020.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Total number of adolescents ages 10 - 17 years referred from Intersections Inc. and received an annual check-up.</td></tr>
<tr><td>Denominator:</td><td>Total number of adolescents ages 10 -17 years.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>UDS, Intersections Inc.</td></tr>
<tr><td>Significance:</td><td>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs.

Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health?damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults.

The Bright Futures guidelines recommend that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health?related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health, related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.</td></tr>
</table>

ESM 10.3 - Percent of adolescents who have heard or read through mass media campaign the importance of an annual check-up.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>At least 30% of adolescents report they heard of annual check-up through social media.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of adolescents who report they learn about annual check-ups through media outlets including social media.</td></tr>
<tr><td>Denominator:</td><td>Total number of Adolescents</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MCH Title V</td></tr>
<tr><td>Significance:</td><td>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs.

Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health?damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults.

The Bright Futures guidelines recommend that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health?related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health, related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.</td></tr>
</table>

ESM 11.1 - Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Implement Technical Assistance Training fo providers at least twice a year to improve competencies in screening, referral and health care management of Children with Speical Health Care Needs
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of providers attending both trainings and report they feel more confident in serving Children with Special Health Care Needs. **Denominator:** Total number of providers who serve children and families.
Data Sources and Data Issues:	MCH Title V
Significance:	Significance The Title V Maternal and Child Health Services Block Grant to States Program guidance defines the significance of this goal as follows: The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home.

ESM 11.2 - Percent of Providers attending Autism Screening Training
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	At least 50% of providers serving CSHCN feel confident they can provide MCHAT screening for AUTISM
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Providers attended Autism Screening Training **Denominator:** Total number of provers serving Children.
Data Sources and Data Issues:	ASMCH Title V
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. (See also the expanded defintion and infographic). Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests for Autism should be done at 18 months of age.

ESM 11.3 - Percent of CSHCN families receive transition training.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	50% of CSHCN families attends the transition training at the Leo o Aiga Center.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families attending Transition Training. **Denominator:** Total number of CSHCN families.
Data Sources and Data Issues:	Leo o Aiga
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.

ESM 13.2.1 - Percent of children 0-3 years receiving fluoride varnish at least twice a year.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of children 9 months -36 months who have access to regular preventive oral health services at least twice a year by 2%.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children ages 9months - 36 months who received topical fluoride varnish treatment at least twice a year.</td></tr>
<tr><td>Denominator:</td><td>Total number of 9 months - 36 months old in the reporting year.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>SILAS</td></tr>
<tr><td>Significance:</td><td>Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</td></tr>
</table>

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - Percent of women registered during Women's Health Week for preventive screenings.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase by 3% the proportion of women ages 21 -44 who gets cervical screenings done.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of women ages 21- 44 years received a cervical screening. **Denominator:** Total number of women ages 21 - 44 years.
Data Sources and Data Issues:	CHC UDS, BCCP
Significance:	Decrease cervical cancer rates.

2016-2020: ESM 1.3 - Percent of Pregnant Women who has heard of the “Fight the Bite” Zika Campaign
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2020, decrease the percentage of pregnant women with Zika infection by 5%.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Total number of pregnant women who received a Zika prevention resource or talk during her pregnancy and prior to delivery.</td></tr>
<tr><td>Denominator:</td><td>Number of pregnant women who received a Zika prevention resource or talk during her pregnancy and prior to delivery.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CHC Prenatal, CHC UDS</td></tr>
<tr><td>Significance:</td><td>Prevent women from getting the Zika virus infection that can lead to an unfavorable birth outcome.</td></tr>
</table>

2016-2020: ESM 4.1 - Number of MCH staff attended the Certified Lactation Counselor training.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the percent of infants who have ever been breastfed and continues until 6 months.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MCH Staff who attended the Certified Lactation Counselor training. **Denominator:** Total number of MCH Staff.
Data Sources and Data Issues:	ASMCH Title V
Significance:	Receiving health education prior and during pregnancy can motivate mothers to breastfeed their babies. But an oncall staff who takes calls anytime to assist with mom who needs counseling and coaching through a hard time can also motivate them to keep breastfeeding.

2016-2020: ESM 4.2 - Percent of women participating at the Breastfeeding Week activities who confirm they are breastfeeding.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of women who are breastfeeding their infants up to 6 months of age.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women participating in the Breastfeeding Week Celebration who are breast-feeding. **Denominator:** Total number of postpartum women.
Data Sources and Data Issues:	MCH Title V Program
Significance:	Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits. AS WIC's certified lactation consultants play a significant role in promoting breastfeeding during pregnancy and after delivery.

2016-2020: ESM 4.3 - Percent of postpartum mothers reported that they received breastfeeding resources and reminders after delivery and before discharge.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>OBJECTIVE 3.1: By May 30, 2020, increase the percent of infants who ever breastfed by 5%.
OBJECTIVE 3.2. By May 30, 2020, increase the percent of infants breastfed exclusively through 6 months by 2%.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of postpartum women who reported that they received breastfeeding resources and reminders after delivery and before discharge.</td></tr>
<tr><td>Denominator:</td><td>Total number of pregnant women with live births int he past year.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MCH Postpartum Data</td></tr>
<tr><td>Significance:</td><td>Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits. AS WIC's certified lactation consultants play a significant role in promoting breastfeeding during pregnancy and after delivery.</td></tr>
</table>

2016-2020: ESM 6.1 - Number of Providers utilizing a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months.
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase number of medical providers utilizing a parent-completed screening tool in the past year.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Providers utilizing a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months.</td></tr>
<tr><td>Denominator:</td><td>Total number of providers in the Community Health Center.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Community Health Center UDS</td></tr>
<tr><td>Significance:</td><td>This ESM will ensure that there is adequate number of medical providers in American Samoa who are confident to provide developmental screening tools for children. This will definitely increase the proportion of children who are screened early for Autism Spectrum Disorder and other Developmental Disorders and are referred to the CYSHCN program, Helping Hands and other early intervention programs.</td></tr>
</table>

2016-2020: ESM 6.2 - Percent of clinical staff trained in the standing operating procedures for referrals to Early intervention and other programs.
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

Measure Status:	Active
Goal:	OBJECTIVE 4.1: By 2020, increase the proportion of children (aged 10-35 months) who have been screened for developmental delays, by 10%
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of clinical staff trained in the standing operating procedures for referrals to Early intervention and other programs. **Denominator:** Total number of qualified clinicians that can provide a developmental screening using the ASQ at the WBCs.
Data Sources and Data Issues:	CHC UDS Data
Significance:	With as many as 1 in 4 children at risk for developmental delay, universal early childhood screening provides an opportunity to identify delays early and intervene during the most critical period of development. Considering that standard developmental screenings may not reveal indications of autism spectrum disorder (ASD) nor social-emotional concerns, it is important to conduct ASD-specific and social-emotional screenings as well. However, approximately 40% of pediatricians do not consistently complete recommended developmental screenings.

2016-2020: ESM 6.3 - Percent of participants in Children's Oral Health awareness month activities.
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2020, increase the percent of children ages 1 – 3 years who had a preventive dental visit in the past year by 25%.
Strategies:</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children ages 1-3 participating in the Oral Health awareness month activities.</td></tr>
<tr><td>Denominator:</td><td>Total number of children ages 1 -3 years.</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CHC UDS Data</td></tr>
<tr><td>Significance:</td><td>Fluoride varnish is one of the most important materials to prevent Early Childhood Cavities, it is easy to apply and well tolerated by children.</td></tr>
</table>

2016-2020: ESM 10.1 - Percent of schools covered by Immunization School Outreach Program.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of adolescents who have a preventive medical services.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of middle and high schools covered by Immunization School Outreach Program.</td></tr>
<tr><td>Denominator:</td><td>Total number of middle and high schools.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Immunization Program</td></tr>
<tr><td>Significance:</td><td>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs.

Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults.

The Bright Futures guidelines recommends that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health-related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.</td></tr>
</table>

2016-2020: ESM 10.2 - Number of high schools covered by Immunization School Outreach Program.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2020, increase percent of adolescents ages 12 – 14 years (6-8 grade students) with HPV vaccination coverage to 76%.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of high schools covered by Immunization School Outreach Program.</td></tr>
<tr><td>Denominator:</td><td>Total number of schools.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Immunization Program</td></tr>
<tr><td>Significance:</td><td>Vaccines save lives. Vaccine-preventable diseases can cause long-term illness, hospitalization, and even death. Skipping vaccines can leave you vulnerable to illnesses such as influenza (flu), pneumococcal disease, and shingles. Vaccines also protect against diseases like human papillomavirus (HPV) and hepatitis B</td></tr>
</table>

2016-2020: ESM 11.1 - Percent of CSHCN families who received care coordination services from CSHCN staff in the past year.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase CYSHCN families of CYSHCN accessing their medical homes.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN received care coordination from CSHCN staff in the past year. **Denominator:** Total number of CSHCN clients.
Data Sources and Data Issues:	CSHCN survey.
Significance:	Lack of transportation was one of the challenges hindering families from accessing their medical homes. By offering transportation means when available helps in increasing utilization and family satisfaction.

Form 11
Other State Data

State: American Samoa

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: American Samoa

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Annually	12		
2) Vital Records Death	Yes	No	Annually	12	Yes	
3) Medicaid	No	No	Never	NA	No	
4) WIC	Yes	No	Annually	12	No	
5) Newborn Bloodspot Screening	No	No	Never	NA	No	
6) Newborn Hearing Screening	Yes	Yes	Daily	1	Yes	
7) Hospital Discharge	No	No	Never	NA	No	
8) PRAMS or PRAMS-like	No	No	Never	NA	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: Births records are available in SILAS.
Data Source Name:	**2) Vital Records Death**
	Field Note: Public Health Epidemiology Surveillance Office is currently inputting all Deaths into SILAS. Data for 2020 and 2021 should be available by 2022.
Data Source Name:	**3) Medicaid**
	Field Note: No access to Medicaid data.
Data Source Name:	**4) WIC**
	Field Note: No access to WIC data electronic database but data is shared as a form of report annually.
Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: There is no Newborn Bloodspot Screening in American Samoa. It is one of ASMCH priorities to plan and implement NBS by FY2024.
Data Source Name:	**6) Newborn Hearing Screening**
	Field Note: ASMCH has daily access to daily Newborn Hearing Screening data in SILAS Database.
Data Source Name:	**7) Hospital Discharge**
	Field Note: MCH Title V does not have access to Hospital Discharge records.
Data Source Name:	**8) PRAMS or PRAMS-like**
	Field Note: PRAMS is not available in American Samoa.