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I. General Requirements

I.A. Letter of Transmittal

September 23, 2015

Michele H. Lawler, M.S., R.D.
Acting Director, Division of State and Community Health
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Room SC-25, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

SUBJECT: MCH Title V Block Grant – 2016 Grant Application / 2014 Annual Report

Dear Ms. Lawler,

On behalf of the Department of Health, I am pleased to submit the enclosed grant application for Year 2016 and the annual report for FY 2014. All components of the application, annual report, and required data forms have been submitted online through HRSA Electronic Handbook website as of September 23, 2015.

The Title V Program provides vital resources and services to women and children in the Territory. The health status of women and children is fundamental to the health of an entire family, which leads to a healthy community, then to a healthy Territory and then to a Healthy American Samoa. Overall, the Title V Program has positively impacted the health status of the Territory’s population within this year and we are appreciative of its contribution to the mission of the Department of Health, which is to “Prevent, Promote and Protect”.

Your continuous support of the Territory of American Samoa’s efforts toward improved health is greatly appreciated.

Sincerely,

Motusa Tuleama Nua
Director 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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

I.E. APPLICATION / ANNUAL REPORT EXECUTIVE SUMMARY

Talofa!

As Director of the American Samoa Title V Program, it is my pleasure to provide this Executive Summary of the Maternal and Child Health (MCH) Services Block Grant 2016 Application/2014 Annual Report.

The purpose of this summary is to highlight key programmatic themes and data points, provide specific examples of MCH program activities in American Samoa.

Each year, a vast amount of information and data is collected as part of the federal application for MCH funding. In addition to federal reporting, the MCH Services Block Grant data are used to prioritize initiatives related to the MCH Needs Assessment. Title V legislation directs states to conduct a statewide MCH Needs Assessment every five years to identify the need for preventive and primary care services for pregnant women, infants, children, adolescents, and individuals with special health care needs. From this assessment, states select seven to ten priorities for focused programmatic efforts over the five-year reporting cycle. The Maternal and Child Health Division Head, Aileen Solaíta and the American Samoa Maternal and Child Health Title V Program (ASMCH) Staff was tasked to spent the past year conducting the needs assessment with an approach focused on not only creating a meaningful, responsive action plan, but also building a strong platform to maximize resources, develop and sustain mutually reinforcing relationships, and deliver outcomes. Unfortunately, the Needs Assessment data was not validated by the department’s Health Information Systems office (HIS) Epidemiologist, Mr. Scott Anesi, who agrees that there is lack of substantial data to back-up the Needs Assessment process and findings. There was lack of coordination and reporting by the previous MCH Coordinator with/to the MCH Director and hence there is no evidence that such a Needs Assessment and Prioritization of Health Needs was made. There is lack of confidence by the Department of Health that the Priority Needs and State performance measures identified in original application was achieved in a well-coordinated, comprehensive, documented process or that informed decisions were made with key leaders, stakeholders, families and community to provide input or feedback with the final application prior to submission. This issue was mentioned during American Samoa’s Grant Review September 3rd, 2015, in Hawaii.

As MCH Director, I request that your office will grant another chance for ASMCH to conduct a second Needs Assessment in the first 6 months of FY2016 in order to establish a more definite baseline data. American Samoa will then work closely with providers and key stakeholders including family advocates and the community to prioritize health needs and enable informed decisions to finalize our State Performance Measures. In the past month, ASMCH have been working closely with the HIS office to retrieve as much information and data currently in the MCH
database but Mr. Scott is willing to take the lead in conducting the second Needs Assessment with the assistance of the SSDI grant. The SSDI Coordinator, Susan Valoaga, CYSHCN Coordinator Jacinta Tialavea and Mrs. Solaita have all been terminated by the Department for various reasons including mismanagement of programs and not performing with the best interest of the Department of Health (DOH).

I have recently appointed Dr. Anaise Uso as the Acting Program Coordinator (until JD is officially adjusted by Department of Human Resources) and will be performing as the Assistant MCH Director when I am away from my post. Dr. Uso will also be the CYSHCN Director and will work closely with CSHCN Program Coordinator and staff to ensure all their program and staff needs are addressed by the MCH Director. Occupational Therapist Mrs. Ipu Eliapo will be the CYSHCN/RHD Coordinator and will be overseeing the CYSHCN staff with their daily operations as well as the MCH Family Coordinator, who will ensure that families and their needs are addressed by staff and/or providers and stakeholders.

Mr. Anesi will be overseeing all SSDI (and/or until an SSDI Coordinator will be hired and who will be working closely with Mr. Anesi) activities who will work closely with the MCH Program Staff to improve MCH Data Capacity and reporting.

American Samoa, along with many national and regional organizations, is exploring options to improve health in communities through increasing collaborative relationships between primary care providers and public health. Successful models of integration share common goals of improving population health, involving the community in defining and addressing needs, relying on strong leadership across disciplines, and sharing data and analysis. Systems integration is taking shape in American Samoa with focus on areas including prenatal care and education, oral health, prevention of Rheumatic Heart Disease, developmental screening, immunization and childhood obesity. The MCH Program values its partnerships and collaborations. Together, we can achieve the common goal of improving the health of mothers, children, and families in American Samoa.

Thank you for all your great work and continuous support to ensure our maternal and children population get their health care needs addressed in order to reduce health disparities in American Samoa.

Margaret Seseapasara,
American Samoa MCH Title V Director
Department of Health

The Title V Block Grant is a Federal-State partnership program to improve the health of mothers, children, and adolescents including children and youth with special health care needs. In American Samoa, the Title V program is managed by the American Samoa Department of Health, also known as the Maternal and Child Health Program (ASMCH). Allocation of Title V funds are based on the American Samoa’s maternal and child health priorities.

Each year American Samoa submit an Application/Annual Report for Federal funds for their Title V MCH Services Block Grant to States Program to the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA), U.S. Department of Human and Health Services (HHS). Without Title V, American Samoa would not have dedicated funding to support core MCH public health functions. Title V is an essential mechanism to assure the health and safety of our nation’s most precious resources: mothers, infants, and children.

The Title V Block Grant program requires all states and territories to report on maternal and child health performance measures and outcomes every year. The application includes: a comprehensive description of strategies and activities that support progress towards achieving national and state goals and data on performance measures and health outcomes.

The Title V program in American Samoa is managed by the Department of Health’s Maternal and Child Health
Program (ASMCH), under the Nursing Division. Services funded by Title V can be envisioned as a pyramid of three tiers consisting of:

- Direct Health Care Services
- Enabling Services
- Public Health Services and Systems

The framework for delivery of MCH services is based on the 10 Essential Public Health Services. Allocation of funds within these categories is based on the state's maternal and child health priorities. These priorities were developed in 2015 following a needs assessment analysis.

**Needs Assessment**

Every five years an assessment of maternal and child health (MCH) needs, and needs for children and youth with special health care needs (CYSHCN), is conducted. The 2015 Needs Assessment Plan will address national and state priorities and performance measures for FY2016 to FY2020. Priorities established from the Needs Assessment guide the use of Title V grant dollars by the Maternal and Child Health Program. The Needs Assessment and corresponding performance measures address the six MCH population health domains: 1) Women’s/Maternal Health; 2) Perinatal/Infant’s Health; 3) Child Health; 4) Children with Special Health Care Needs (CSHCN); 5) Adolescent Health; and 6) Cross-Cutting or Life Course.

**Title V Maternal and Child Health Priorities, FY 2015–2019: (Numbered according to Priority)**

1. Improve system of care for families with children and youth with special health care needs.
2. Increase access and awareness to adequate prenatal care.
3. Reduce smoking among child bearing age women before, during and after pregnancies.
4. Reduce Infant Mortality rate
5. Reduce the incidence of Rheumatic Heart Disease.
6. Increase Breastfeeding in 3 and 6 months infants.
7. **Increase evidence based screening for all children 0-5 years of age.**
8. Increase access and services to oral health care.
9. Increase immunization coverage rates

**Title V Emerging Needs and Five Year Action Plan**

The Maternal and Child Health Priorities for FY2016-2020 are divided by population domain and described below, including the population-based national performance measures (NPMs) chosen to track prevalence rates and demonstrate impact. State performance measures (SPMs) will be reported in 2016. Current status and activities are summarized, as well as a sample of the Title V supported strategies planned by the ASMCH Program to address the Health Priorities over the next five years. There is no current substantial data to support the Needs Assessment previous MCH Division Head Aileen Solaita reported in the original application narrative submitted in July. Current MCH Director, Mrs. Margaret Sesepasara; Acting ASMCH Title V Coordinator, Dr. Anaise Uso; current MCH staff; and DOH Epidemiologist, Scott Anesi, have decided that American Samoa’s MCH Title V and its partners will collaborate to plan and implement a second Needs Assessment which will be conducted in the first 6 months of FY2016 so that a more definite report with baseline data will be established. State Performance Measures will then be finalized and ready to be reported by June 2016.

ASMCH Title V office is currently working closely with Mr. Anesi to identify at least 7-8 Priority Needs based on current data ASMCH and HIS have. They are mentioned above. Changes are anticipated concerning the current Priority Health Needs of American Samoa mentioned in the original 2016 Application Narrative. Once the Needs Assessment is completed, the ASMCH Title V office will then identify the top 7 – 8 Priority Needs and the 5-Year
Strategies and Planned Activities will be revised and reported by June 2016.

Challenges and Accomplishments:

It has been challenging to complete program mission with previous management team, however, with current changes in place, and continual support from department key leaders at the National, State, and Local Community levels, ASMCH anticipates future improvements in executing goals and objectives. We anticipate a huge need to strengthen existing partners and collaborating efforts in order to leverage resources and achieve better health outcomes for the MCH population. There is a need to improve service capacity and competency within existing health workforce by providing quality technical assistance at the local and national level. There is also a need to assure standardized service delivery by identify quality improvement projects to monitor progress. MCH will continue to identify evidence based strategies and innovative approaches that are culturally sensitive and acceptable to increase access to care. MCH will continue to inform and increase awareness and strengthen it's presence in the community of not only the program's goals and objectives, but also to continue engaging family participation in all program activities.
II. Components of the Application/Annual Report

II.A. Overview of the State

II. A. Overview of the State

Overview of the State

Geographic Description

American Samoa is an unincorporated island territory of the U.S. which lies approximately 2,400 miles Southwest of Hawaii and has a population of 55,519, predominantly made up of native Samoans who are recognized as US nationals. Fifty-eight percent of families have incomes below the U.S. poverty level. American Samoa faces very similar issues with provision of healthcare as other low-middle income island populations, particularly other Pacific island nations, who face unique issues of healthcare supply and demand, consistency of service provision and outward migration of healthcare professionals. American Samoa is considered both a medically underserved area and a healthcare professional shortage area.

Districts, Counties, Villages

Based on the 2010 Census the Territory of America Samoa has a population of 55,519 residents and represents a 0.03% decrease from the 2000 Census of 57,291 residents. Mid-year population for 2013 was estimated at 62,610 residents, a declining trend in the population. The mid-year population estimates, as calculated by the Department of Commerce, may vary when compare to those calculated elsewhere. Sources of date most likely a factor for the cause of this critical disparity.

American Samoa based on the 2013 Statistical Year Book is divided into 3 geo-political districts: Western District, Eastern District and Manu’a District. However, for those who were born in the early 1970s would identify Central District as the 4th district. In addition to that, Central District is divided into Central I and Central II. Districts are broken down into counties and counties into villages. Eastern district has 3 counties, Western has 3, Manu’a has 5 and Central has 3 in which Central is also broken down to Central I, which consists of 1 county and Central II has 2 counties. The population distribution for these districts show that there are residents 9,252 (16.6 %) in the Western District, 7,831 residents (14.1%) in the Eastern District, 35,536 residents (64%) in the Central District, and 1,143 (2.1 %) residents in Manu’a District and 17 in Swains Island.
<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>CENTRAL I</th>
<th>CENTRAL II</th>
<th>DISTRICT</th>
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<td>9) Leone</td>
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<td>10) Maloata</td>
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<td>11) Nua</td>
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<td>9) Masausi</td>
<td>9) Utulei</td>
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<td>10) Masefau</td>
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Population

As of 2014, America Samoa has an estimated population of 62,610 people. It is a small island with a land area of 76 square miles. Tutuila contains two-thirds of the total area and is home to 97 percent of the 55,519 people. The number of American Samoan residents in poverty is high based on US standards with a primary factor being the lower minimum wages when compared to the United States. In examining the 1999 poverty status of residents, 61% of all individuals in American Samoa live in poverty; with 47.9% of residents 65 years and older and 66.5% of all the related children 0–17 years of age living in poverty. Additionally, 58.3% of the families are below the poverty level; including, 62.2% of families with related children less than 18 years of age and 67.3% of families with related children less than 5 years.

In assessing the population distribution by age (Table 1), American Samoa has a relatively young population with over one-third (35%) of the population less than 15 years of age. For the total population, the median age stands at 21.3 years with 46.4% of the population less than 20 years of age, 46.8% between 20-59 and 6.8% who are 60 years and above. Of the 2010 Census of 55,519, 11.9% of the population were under the age of five.

Ethnicity / Race

Of this total population, 97.3% of the residents reported one ethnicity or race and 2.7% reported two or more races or ethnic groups. The population of the Territory is described as 0.9% White, 0.1% Hispanic or Latino, 0% Black or African American, 3.6% Asian, 2.7% two or more races or other and 92.6% native Hawaiian or other pacific island
which 88.9% are Samoans, 2.9% are Tongans, 0.5% are Fijians and 0.3% fall into other Pacific Islander. The proportion of the American Samoa born population remained above 50% and slightly increased by 0.9% compared to 2000 Census and the foreign-born residents decreased from 43.3% in 2000 Census to 42.4 in 2010 Census. The majority of foreign-born immigrants were from neighboring Samoa with 30.9% in 2010 Census to 29.4% and 6.2% US born immigrants.

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<tr>
<td>50-54</td>
<td>2,678</td>
<td>4.8%</td>
</tr>
<tr>
<td>55-59</td>
<td>2,057</td>
<td>3.7%</td>
</tr>
<tr>
<td>60-64</td>
<td>1,481</td>
<td>2.8%</td>
</tr>
<tr>
<td>65-69</td>
<td>957</td>
<td>1.7%</td>
</tr>
<tr>
<td>70-74</td>
<td>653</td>
<td>1.2%</td>
</tr>
<tr>
<td>75+</td>
<td>657</td>
<td>1.1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>55,519</td>
<td>100%</td>
</tr>
</tbody>
</table>

Family Household Type

There are 9,688 households in American Samoa of which 8,834 (91.2%) are family households and 854 are non-family households. Of the family households, 6,501 (73.6%) are married-couple families of which 4,728 are households with children under 18 years of age and 1,630 (16.8%) are female head of household of which 625 have children less than 18 years of age. Of the total household of all types, 7,375 (76.1%) are households with an individual under 18 years of age.

Social & Cultural Structure

The social structure of American Samoa is deeply rooted in the extended family or aiga system. It is a system consisting of a group of people related by blood, marriage or adoption, acknowledging a common allegiance to a chief or Matai, who regulates their activities. The chief assumes the trustee functions over family land and property. Extended families own 90% of total land (communal land).
Economy & Employment

The number of American Samoan residents in poverty is high based on the US standards with a primary factor being the lower minimum wage when compared to the mainland United States. The current minimum wage for American Samoa varies and it ranges anywhere from $4.51/hour to $5.59/hour which is still below the federal minimum wage.

The Fair Minimum Wage Act of 2007 (Public Law 110-28) ordered new wage increases for American Samoa. The law stipulated $0.50 increases to current local minimum wages every year until it reaches the US minimum wage of $7.25 an hour. Local minimum wages for various industries in American Samoa had another fifty-cent increase on May 25, 2009. In 2010, a bill was passed to postpone the 50 cents increases for 2010 and 2011 until September 30, 2012 when this issue will be discussed again in the U.S. Congress. Another bill was approved by Congress in 2012 to postpone the minimum wage increase (50 cents) until September 30, 2015. The current minimum wage rates by industry in American Samoa still remain on the last 50 cents increase on May 25, 2009.

The tuna canning industry is the largest source of private-sector employment on the island. The territory is scheduled for more wage increase in September 2015 and additional increases are scheduled every 3 years; however, the Governor is protesting further wage increases and said he would “pursue changes in U.S. Law to allow American Samoa to take control of its minimum wage.” The average cost of gas per gallon was $4.40. Based on 2014, the average cost of 1 litre of fresh milk is $1.9, a small dozen of egg is $2.25 and a loaf of bread is $1.99. Based on this costs and the minimum wage for American Samoa, the cost of living is high.

Health Insurance

The only health insurance that is available to majority of the citizens of American Samoa is Medicaid. Tri-Care is available to military families. There is no third party health insurance as according to the Medicaid Director, “due to American Samoa’s past history of poor payments to hospital providers and vendors off island, providers do not want to sign provider agreements without ASG putting up at least $10 million in an escrow account to prepay for off-island referrals.”

So currently, the Governor continues to pursue options with the State of Hawaii re-establish access to Hawaii hospital providers for medically necessary care not available on island.

Health Reform

Because American Samoa is an un-incorporated territory of the United States, it has local voting rights, non-voting delegates in Congress, and U.S. military and court protections. American Samoa has limited application of the Constitution like trial by jury is not guaranteed. American Samoa also pay only part of American federal taxes, pay social security taxes, medicare taxes, and import / export taxes. The citizens do not pay federal income taxes and their income taxes go to the government of the Territory.

Due to the way that Congress created the Affordable Care Act, there was much concern since some, but not all, of the law’s provisions apply to the Territories. Because the residents of U.S. territories do not pay income taxes, the
tax subsidies that Americans receive to help pay for insurance to not apply to them. 

In July 2014, the Obama administration decided to simple exempt insurers operating in the territories from the coverage requirements in the Affordable Care Act.

**Emerging Issues**

American Samoa is the smallest Territory and yet residents have realized the population is growing and with that concern, there are many of them that are experiencing poverty and unemployment. Though there was an increase in unemployment from 2012 to 2013 by 9 percent,

Furthermore, the Governor’s proposed 2016 local budget have all been decreased 10% from fy2015’s budget for all government agencies.

In American Samoa, at least one child between the ages of 1 to 17 dies each month. These deaths are from preventable diseases. Recent efforts have been made to improve awareness of the rise of illnesses and diseases through the prenatal home visiting and Children with special health care needs follow up visits.

**Title V Priorities**

In light of the geographic, demographic and political issues surrounding American Samoa, this is a critical time for the Title V program to assess priorities. The process used by the Title V Program Manager for determining the needs and priorities of the program. Primarily, the five-year assessment is used to evaluate priorities. However, efforts are made to align priorities with ongoing needs assessment efforts, priorities of the Leadership Team within the agency.
II.B. Five Year Needs Assessment Summary

II.B.1. Process

II.B.1. Process:

Vision, Mission and Goals:

The overall process that was used to conduct the Title V comprehensive Needs Assessment for determining the needs for pregnant women, mothers, infants, children, adolescents, and children and youth with special health care needs is an ongoing process that is important and relevant to program planning and development, effective and efficient implementation, and accurate monitoring of interventions. The Maternal and Child Health (MCH) Title V Five-Year Needs Assessment process was guided by the overall vision of the Department of Health, which is, “Healthy Families, Healthy Communities, Healthy American Samoa.”

The needs assessment participants, the MCH 2016-2020 team, determined the mission and goals of the process. The mission of the MCH Bureau was adopted as the mission of MCH 2016-2020, and the goal for each of the three MCH population groups was identified.

<table>
<thead>
<tr>
<th>Vision:</th>
<th>Healthy Families, Healthy Communities, Healthy American Samoa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission:</td>
<td><em>Provide leadership to improve the health and well-being of the nation’s mothers, infants, children and youth, including children and youth with special health care needs, and their families.</em></td>
</tr>
<tr>
<td>Goals:</td>
<td>To enhance the health of American Samoa women and infants across the lifespan.</td>
</tr>
<tr>
<td></td>
<td>To enhance the health of American Samoa children and adolescents across the lifespan.</td>
</tr>
<tr>
<td></td>
<td>To enhance the health of all American Samoa children and youth with special health care needs across the lifespan.</td>
</tr>
</tbody>
</table>

The Needs Assessment methodologies were developed through an internal work group with a focus on the vision and mission statements above and were designed to be consistent with the MCH Services Title V Grant Guidance provided by the Health Resources and Services Administration (HRSA).

The process was designed to be consistent with the HRSA Maternal and Child Health Bureau (MCHB) conceptual framework, State Title V MCH Program: Needs Assessment, Planning, Implementation, and Monitoring Process. The MCH Epidemiology’s focus is to promote and improve the health and well-being of women, children and families by building data capacity at the Territorial and local levels to effectively use information for public health.
Beyond these specific goals for the MCH Title V Block Grant alone, the leadership team identified ways to help guide the completion of the needs assessment. The leadership team for the MCH Division consists of the Project Director, Division Head II, Manager, Coordinator and Supervisor of MCH programs. After reviewing the first needs assessment that was conducted for MCH 2010 – 2015, the leadership team decided to utilize some ways from the past needs assessment to make better the needs assessment for MCH 2016-2020. The objectives were to be less burdensome to staff, but yet assured that staff expertise was fully utilized; to obtain as much stakeholders’ input as possible and recognizing their involvement and to assure the outcome of the needs assessment has value.

The process of conducting the needs assessment was important because it gave us an updated snapshot of the six population health domains: maternal/women’s health, perinatal / infant health, children’s health, adolescent health, children and youth with special health care needs (CYSHCN) and cross cutting / life course. It engaged stakeholders and MCH staff in identifying priority needs and what they think can be done to address those issues; and set the stage for a coordinated effort to address the priority needs. The key steps for the needs assessment process are outlined in Figure 1.

Figure 1. American Samoa Title V Needs Assessment Process.

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**Stakeholder Involvement**

Stakeholders and community members were engaged through focus groups, online survey, face to face survey, key informant interviews, priority selection and an ongoing public comment period. The focus groups were not only conducted among community members, they were also conducted by community members experienced in focus group facilitation. A survey was conducted to identify needs and 579 responses were received. The surveys were passed out to participants and they in turn disseminate the survey, which was used to obtain a high number of responses. Key informant interviews were conducted among 6 team leads that were leading each health domain. Stakeholders were able to review the analysis, make comments, and were part of recommending priorities. Over 70 stakeholders participate in the prioritization process. The recommendations and opinions from stakeholders were utilized when determining the priorities. Sections of the needs assessment were printed and discussed during meetings for public input from May 2015 to June 2015.

**Methods and Data Sources**

**Quantitative Methods**

A thorough examination of the health status of women and children in American Samoa was conducted by analyzing the most current information available by population domain. Trends over time were presented for all data where possible and information was stratified by relevant variables including age, race/ethnicity, education, income, gender,
health insurance coverage and CYSHCN status. Comparisons with national averages and Healthy People 2020 objectives were made when possible to provide better context for the data provided. Due to a lack of finalized 2014-2015 data regarding American Samoa’s statistics, the following data sources were used:

Behavioral Risk Factor Surveillance System
Children’s Services Survey
Children with Special Health Care Needs Needs’ Assessment
Department of Health General Survey
Family Planning Program
Pregnancy Risk Assessment Monitoring System
Prenatal Services Survey
Uniformed Data System Report

Qualitative Methods

Focus Group

Qualitative data were gathered from each of American Samoa’s 6 public health districts to gain insight into the needs of MCH populations and areas to improve the delivery of services. Data were collected through focus groups from the 4 public health districts and through key informant interviews in 2 districts, which are Ta’u and Ofu. Key informant interviews were used as a culturally appropriate method of gaining insight into the most remote parts of the Territory of American Samoa. Community members with prior experience conducting focus groups were responsible for recruitment and facilitation. Facilitators were asked to recruit potential or current users of services in their respective districts.

Table 1: Needs Assessment Focus Groups by Location and Category Discussed:

<table>
<thead>
<tr>
<th>DISTRICTS</th>
<th>Perinatal Health</th>
<th>School Readiness</th>
<th>CYSHCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western</td>
<td>16-39 yrs. old</td>
<td>16-39 yrs. old</td>
<td>20-40 yrs. old</td>
</tr>
<tr>
<td>Central II</td>
<td>16-39 yrs. old</td>
<td>16-39 yrs. old</td>
<td>20-40 yrs. old</td>
</tr>
<tr>
<td>Central I</td>
<td>16-39 yrs. old</td>
<td>16-39 yrs. old</td>
<td>20-40 yrs. old</td>
</tr>
<tr>
<td>Eastern</td>
<td>16-39 yrs. old</td>
<td>16-39 yrs. old</td>
<td>20-40 yrs. old</td>
</tr>
<tr>
<td>Ta’u (Interview)</td>
<td>Ta’u (Interview)</td>
<td>Ta’u (Interview)</td>
<td></td>
</tr>
<tr>
<td>Ofu (Interview)</td>
<td>Ofu (Interview)</td>
<td>Ofu (Interview)</td>
<td></td>
</tr>
</tbody>
</table>

Key Informant Interview

Interviews were conducted with the 9 supervisors in the MCH workforce in American Samoa. One interview was conducted per population. The key areas discussed during the interviews were included: identification of needs priorities,
barriers to accessing services, areas of disparity and the needs of the public health workforce especially in the areas of maternal and child health and children and youth with special health care needs.

**Stakeholder Survey**

Paper surveys were disseminated to stakeholders throughout the Territory to identify needs and priorities. Respondents were asked to rank the National Performance Measures (NPM) and identify needs specific to American Samoa that are outside the scope of the NPMs.

**Public Health Workforce Survey**

A separate, but similar, paper survey was disseminated to employees of the Department of Health and its workforce at the various locations their offices are located at and to those working in the community health centers. Respondents were asked to rank the NPMs and identify additional needs related to MCH populations, workforce development and agency capacity.

**Public Comment**

Throughout the process, public input was solicited through meetings and interviews. The Title V Needs Assessment findings were displayed at the main MCH headquarters. Notifications were emailed to partners, committee members and known stakeholders with an invitation for comments. Comments were shared at the meetings or shared to team leads for each of the six population domains.

**Interface Between Needs Assessment Data, Priority Needs and State Action Plan Chart**

MCH program staff and data team with the epidemiology staff reviewed all data from the quantitative and qualitative analysis in order to select the potential priority needs for the state for the population domains relevant to their work. Staff individually indicated their top needs based on the data reports and then a consensus was developed across all members. They were asked to primarily consider whether the data indicated an area of need, whether Maternal and Child Health had the capacity and authority to address the need and if the need was measurable. A total of 45 priorities were identified; however, after much discussion within the few meetings that were conducted, 20 were selected and brought to stakeholders for prioritization.

Stakeholder prioritization occurred during two meetings. Meetings were held in the Central Districts where it is mostly common and easily accessible to stakeholders and participants. A total of 70 stakeholders attended representing 7 government/government related agencies, 7 community organizations attended. Following group discussions, each stakeholder individually completed a prioritization tool. The tool was designed to rate each need on a scale of 1 to 5 based on the following criteria: seriousness of the issue, health equity, economic impact, trend, magnitude of the problem and importance. Stakeholders provided key activities and strategies within each area of need to inform the development of the State Action Plan Chart.

The individual rating tools were analyzed across the two meetings to determine the highest rated priority needs in each domain. When determining priorities, the needs with the highest rating in each domain were considered first. The data and results from survey rankings were reviewed to assess consistency and confirm an area of need. Needs were then aligned with a NPM when possible (displayed in Table 2).

**Table 2. Linkage Between Priority Needs and National Performance Measures**
<table>
<thead>
<tr>
<th>#</th>
<th>POPULATION DOMAIN</th>
<th>PRIORITY NEED</th>
<th>NATIONAL PERFORMANCE MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Women / Maternal Health</td>
<td>Prevent maternal mortality</td>
<td>Well woman visits</td>
</tr>
<tr>
<td>2</td>
<td>Perinatal / Infant Health</td>
<td>Reduce infant mortality</td>
<td>Perinatal Regionalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Breastfeeding</td>
</tr>
<tr>
<td>3</td>
<td>Child Health</td>
<td>Reduce childhood obesity</td>
<td>Physical</td>
</tr>
<tr>
<td>4</td>
<td>Child Health</td>
<td>Promote development screenings among children.</td>
<td>Developmental screenings</td>
</tr>
<tr>
<td>5</td>
<td>CSHCN</td>
<td>Improve systems of care for CYSHCN</td>
<td>Medical Home</td>
</tr>
<tr>
<td>6</td>
<td>Adolescent Health</td>
<td>Prevent being bullied or bullying others.</td>
<td>Bullying</td>
</tr>
<tr>
<td>7</td>
<td>Adolescent Health</td>
<td>Promote adolescent health.</td>
<td>Adolescent well visit</td>
</tr>
<tr>
<td>8</td>
<td>Cross-Cutting / Life Course</td>
<td>Promote oral health among all populations.</td>
<td>Oral Health</td>
</tr>
</tbody>
</table>

Mini-work groups for each domain consisting of staff in MCH programs, Data Team, developed the State Action Plan Chart and strategies were identified based on suggestions from the stakeholder meetings, focus group findings and a review of the evidence base for each NPM.

II.B.2. Findings

Results on comprehensive needs assessment.

II.B.2.a. MCH Population Needs

The following summary provides an overview of the quantitative findings related to the identified priority needs and NPMs and qualitative findings from focus groups and key informant interviews. Each domain includes a summary of
strengths needs relative to the identified priority needs and national priority areas. A more comprehensive discussion of strengths and needs from all findings are provided in the full Needs Assessment report.

**Maternal/Women’s Health**

**Maternal Mortality**

The maternal mortality ratio (number of pregnancy-related deaths per 100,000 live births) increased from 9.4 in 2012 to 18.1 in 2013. That number doubled and American Samoa LBJ has a Fetal and Infant Mortality Review Committee to review all maternal deaths and a MCH Representative is part of that team. Of the deaths that were related to pregnancy, 99% of the women were Samoans. The most common cause of death among pregnancy-related cases was from complications during pregnancy or at childbirth. Hypertension and cardiac conditions were common causes as well, highlighting the importance of managing chronic conditions prior to pregnancy.

**Preventive Visit**

Although overall the percentage of women receiving a preventive medical visit between 2009 and 2013 in American Samoa has been fluctuated, there has been an increase in 2014 from 19.9% to 29%. 100% of Asians women reported having seen a provider. The percentage of women receiving a preventive visit had either adequate or an A+ prenatal care.

**Family Planning**

The percentage of births that were not planned in American Samoa increased from 30.0% in 2009 to 42.0% in 2012. But it decreased in 2013 from 42.0% (2012) to 40.7%.

**Qualitative Findings**

**Table 3: Maternal/Women’s Health Qualitative Findings**

<table>
<thead>
<tr>
<th>FOCUS GROUPS: PERINATAL HEALTH</th>
<th>Individual – level Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*Limited access to use of contraception</td>
</tr>
<tr>
<td></td>
<td>*Lack of transportation</td>
</tr>
<tr>
<td></td>
<td>*Contraception not available at the health centers</td>
</tr>
<tr>
<td></td>
<td>*Lack of understanding in contraceptive measures</td>
</tr>
<tr>
<td></td>
<td>*Couldn’t get an appointment</td>
</tr>
<tr>
<td></td>
<td>*Didn’t realize they were pregnant</td>
</tr>
<tr>
<td></td>
<td>*Lack of money/insurance coverage</td>
</tr>
</tbody>
</table>
**Strengths and Needs**

The data indicate areas where some groups of American Samoa’s population are achieving acceptable outcomes.
The percentage of women receiving a preventive visit in American Samoa is increasing but at the same time, doesn’t guarantee they are showing up for all scheduled prenatal care visits. In American Samoa, the percentage is highest among Asian women who are taking advantage of the services rather than the Samoan women.

There is a need to reduce the maternal mortality ratio in American Samoa. Not only has the statistic been increasing, there are differences among racial/ethnic groups. Additionally, the percentage of women who reported visiting a medical provider in the past year increased from 2013 to 2014 by 10%, efforts should be made to ensure that this percentage does not decrease further and to utilize how this can boost up the number of prenatal visits that need to be conducted for pregnant women.

Programmatic Efforts

Continued Efforts:

- The Fetal and Infant Mortality Review Committee has provided the state with important findings on the causes of maternal mortality. The MCH Representative will continue to join this committee to gain updates.

Opportunity Efforts:

- Need policies and procedures of FIMR committee.
- Promote well-woman visits and pre- and inter-conception care
- Promote family planning services and get them out into the community health centers.

Perinatal Health

Infant Mortality

From 2010 to 2012, the infant mortality rate decreased from 14.9 to 3.4. However, it increased in 2013 from 3.4 to 4.3. Though it has increased, it is still lower than the Healthy People Objective 2020 target: 6.0 infant deaths per 1,000 live births. A significant effort to decrease infant mortality from 2010 to 2012, which MCH will look further into what was done different in those years that has caused a decrease in infant mortality.

Perinatal Regionalization

The American Samoa only hospital (LBJ Tropical Medical Center) is the only hospital that provide delivery services; but rarely in the community health centers and a few occur at the homes or while mother is in labor via ambulance or personal vehicle. The LBJ Nursery Intensive Care Unit (NICU) would be the closest place to a high level facility where deliveries are conducted. The rate of very low birth weight from 2009 to 2013 has been fluctuating and currently in 2013, the number has decreased from 9 births in 2012 to 4 births in 2013.

Breastfeeding

Ever Breastfed

The percentage of infants ever breastfed in American Samoa have increased based on a home visiting screening in 2014, 80% of women have identified that they have tried breastfeeding before discharging from the hospital. Based on those number of women, majority of the 80% are of Samoan race.

Exclusively Breastfed at Six Months

Despite an increase in 2014 where women identified they have tried breastfeeding, exclusively breastfeeding child up to six months is very low where at 3 weeks post-partum, it dropped down to 39.3%. Most did not stop feeding; however, they were supplementing their breastfeeding with formula. Though there are some benefits to some breastfeeding over none at all, but from obesity prevention perspective, mixed feelings is associated with the least
favorable outcomes.

**Safe Sleep**

Healthy People 2020’s safe sleep objective is to increase the percent of infants sleeping on their backs to 75.9%. In American Samoa, there are rarely any cases of children dying from unsafe sleep except for one infant death that was identified in 2013 from SID.

**Qualitative Findings**

Table 4. Perinatal Health Qualitative Findings

<table>
<thead>
<tr>
<th>FOCUS GROUPS: PERINATAL HEALTH</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual – level Factors</strong></td>
<td>*Familiarity of provider with client leads to clients not to attend visits.</td>
</tr>
<tr>
<td></td>
<td>*Lack of transportation</td>
</tr>
<tr>
<td></td>
<td>*Lack of awareness on available services for women</td>
</tr>
<tr>
<td></td>
<td>preconception care, perinatal, pre-natal care and post partum care.</td>
</tr>
<tr>
<td></td>
<td>*Lack of benefits of breastfeeding, SIDs, etc.</td>
</tr>
<tr>
<td><strong>Structural – level Factors</strong></td>
<td>*Lack of support system</td>
</tr>
<tr>
<td></td>
<td>*Lack of awareness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KEY INFORMANT INTERVIEWS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority Needs</strong></td>
<td>*Perinatal regionalization system</td>
</tr>
<tr>
<td></td>
<td>*Safe Sleep</td>
</tr>
<tr>
<td></td>
<td>*Breastfeeding education</td>
</tr>
<tr>
<td></td>
<td>*Lack of services in Manu’a (Ta’u and Ofu)</td>
</tr>
<tr>
<td><strong>Individual – level Factors</strong></td>
<td>*Lack of awareness on benefits of breastfeeding</td>
</tr>
<tr>
<td></td>
<td>*Lack of support from families and providers</td>
</tr>
<tr>
<td></td>
<td>*Lack of services in Manu’a (Ta’u and Ofu)</td>
</tr>
<tr>
<td><strong>Structural – level Factors</strong></td>
<td>*Lack of access to health centers</td>
</tr>
<tr>
<td></td>
<td>*Lack of transportation</td>
</tr>
<tr>
<td></td>
<td>*Lack of fund to pay for services</td>
</tr>
<tr>
<td></td>
<td>*Poor customer service</td>
</tr>
</tbody>
</table>

**Strengths and Needs**

Although there are no clear instances in the areas examined where American Samoa’s population is meeting or exceeding national averages or HP 2020 objectives, certain population groups are. The infant mortality rate in infants is strength in American Samoa from 2010 to 2012 and it will research methods or instances that happened that led
to the decrease and utilize it to decrease the current number in 2013 for the upcoming years.

Though there may have been one case reported within the last 5 years for unsafe sleep as a cause, there is still need to improve and conduct awareness to the public to prevent any further deaths from it. Breastfeeding initiation and exclusivity will be promoted among younger mothers and those with lower educational attainment. There is also a need to reduce the disparities in American Samoa’s perinatal regions, and ensure that all very low birth weight infants throughout the state are receiving care even at the only hospital on the island. There should be midwives that can be considered for American Samoa. Addressing all three of these needs will help ensure the infant mortality rate does not increase further.

**Programmatic Efforts**

**Continued Efforts:**

- The Baby Friendly Hospital Initiative has already been implemented, but needs to be improved and encouraged.
- MCH program has implemented its Baby Friendly Work Initiative to encourage breastfeeding for working mothers.

**Opportunity Efforts:**

- Need to implement Quality Improvement Activities for health centers and workplaces.

**Child Health**

**Developmental Screening**

In American Samoa, Part C Helping Hands Program conducts developmental screenings; however, not all children are screened and if they are eligible for Part C Helping Hands program based on their screening tool, then that child is enrolled in their program. Though there may be a lot of cases of children with developmental delays, the Part C Helping Hands program are only identifying serious cases and their number of cases usually averages 40 children they serve in a year. The Maternal, Infant and Early Childhood Home Visiting program conducts developmental screenings and those data will not be available until October 2015.

**Non-Fatal Injury**

The rate of hospitalizations due to non-fatal injury among children was 97.2% in 2009 and it decreased in 2010 by 19.6%; however it increased again in 2011 by 6.4%, and increased again by 2% in 2012 and had a dramatic drop from 86% in 2012 to 10% in 2013.

**Physical Activity**

There was no notable change in the overall percentage of children performing physical activity at least 30 minutes daily between 2009 to 2013 in American Samoa. The most notable disparity is between genders, with 85.2% of boys performing physical activity for at least 30 minutes daily compared to 79.7% of girls.

**Qualitative Findings**

**Table 5. Child Health Qualitative Findings**
FOCUS GROUPS: CHILD’S HEALTH

Individual – level Factors

*Lack of transportation  
*Lack of a developmental screening  
*Lack of knowledge about school readiness  
*Limited parent’s understanding of nutrition

Structural – level Factors

*Lack of support system  
*Transportation challenges  
*Village immunization campaign only limited to flu shots  
*Lack of staff  
*NO New Born Screenings  
*Lack of Finances

KEY INFORMANT INTERVIEWS

Priority Needs

*Physical Activity  
*Awareness  
*Lack of services in Manu’a (Ta’u and Ofu)

Individual – level Factors

*Lack of motivation from peers  
*Lack of support from families  
*Culture  
*Lack of Finances  
*Lack of services in Manu’a (Ta’u & Ofu)

Structural – level Factors

*Lack of access to clinics  
*Inaccessible facilities  
*Lack of professional provider (pediatricians, nurses, etc.)  
*No children’s visits conducted after 18 months.  
*Lack of health coverage  
*No leveraging of services  
*Poor customer services

Strengths and Needs

A major decline has been seen in the rate of hospitalizations due to non-fatal injury among children. The MIECHV program is also conducting developmental screenings voluntarily.
Despite an additional group that is conducting developmental screenings, less than half of American Samoa’s children receive this screening. Additionally, there are disparities in American Samoa related due to no health insurance coverage except for Medicaid. Obesity levels in American Samoa are very much higher than the national average, and disparities exist due to income levels and education level. Although American Samoa’s physical activity data is increasing, a comprehensive effort is still needed to ensure that females are performing physical activities and that children ages 6 to 11 continues to perform physical activity into adolescence.

**Programmatic Efforts**

**Continued Efforts:**

- The Department of Health with the collaborative efforts from the MCH Program, the Environmental Health Services Program and the Non-Communicable Disease Program implemented Wellness Activity for the Department of Health since 2014 and will continue to monitor its results. It was created to encourage the community to get involved and for the local department of public health’s workforce to practice what they are promoting.
- MCH also took initiative to conduct nutrition classes for public schools during lunch time and will continue to collaborate with the DOE School lunch program to continue such effort.

**Opportunity Efforts:**

- Developmental screenings are newly conducted by the MIECHV program which is under the MCH program, but there is opportunity to increase this reach and promote screenings for children not using the public health system.

**Adolescent Health**

**Suicide**

The adolescent suicide death rate remains stagnant in American Samoa. However, based on statistics from 2011, American Samoa teens are nearly twice as likely to make a plan to commit suicide versus the U.S. 40% said they have made a plan at least once, 22% said they considered suicide in the past 12 months, 82% of American Samoa students have borderline to severe depression. American Samoa teens are almost three times as likely to attempt suicide versus the U.S.

**Bullying**

Bullying is very high in American Samoa. During a class discussion on the topic of bullying in a combination of classes from 3rd to 6th graders in one on the public schools, 80% of all who were present in the room attest to have experienced being bullied or bullied others. Racial disparities exists where Samoan adolescents most likely are bullying children of other races or other samoan children that do not speak the native language. Females experienced bullying more often than do males.

**Physical Activity**

When it comes to the percentage of high school students who are physically active every day of the week, American Samoa average has most likely decreased. There has been an overall decline in the percentage of high school students who are physically active every day of the week since 2013. In 2013, 40% overall youths performed 60 minutes of physical activity per day. Students in all four grades (9th – 12th) reported less physical activity in 2012/13. 18% girls and 28% boys are physically active for at least 60 minutes a day.

**Non-Fatal Injury**
The rate of hospitalizations due to non-fatal injury among adolescent increased from 2008 to 2012. Though a major decrease in the children’s category as well as the adolescents, but in year 2013 to 2014, the number started to climb up due to pink eye and Chikungunya outbreaks. The disparity due to gender is more pronounced among adolescents than children.

Preventive Visits

In American Samoa, the only preventive visits that are being conducted are done for infants from 3, 6, 9, 12, 15 and 18 months. After 18 months, there are no more children’s visits and no adolescent preventive visits for adolescents. The disparity is due to lack of health care providers to conduct such visits.

Qualitative Findings

Table 6. Adolescent Health Qualitative Findings
## FOCUS GROUPS: ADOLESCENT HEALTH

| Individual – level Factors | *Lack of transportation  
|                           | *Lack of providers to serve children  
|                           | *Bullying  
|                           | *Culture’s view on sex education |
| Structural – level Factors | *Lack of support system  
|                           | *Lack of teen clinics  
|                           | *Transportation challenges  
|                           | *Lack of health care providers  
|                           | *Poor customer service  
|                           | *Lack of Finances  
|                           | *Provider’s familiarity portrays by teens as a barrier.  
|                           | *Culture |

## KEY INFORMANT INTERVIEWS

| Priority Needs | *Physical Activity  
|               | *Awareness  
|               | *Lack of services in the remote islands of Manu’a (Ta’u & Ofu) |
| Individual – level Factors | *Lack of motivation from peers  
|                           | *Lack of support from families  
|                           | *Culture  
|                           | *Lack of Finances |
| Structural – level Factors | *Lack of access to clinics  
|                           | *Inaccessible facilities  
|                           | *Lack of professional provider (pediatricians, nurses, etc.)  
|                           | *No children’s visits conducted after 18 months.  
|                           | *Lack of health coverage  
|                           | *No leveraging of services  
|                           | *Poor customer service |

### Strength and Needs

American Samoa has seen doing well in reducing hospitalizations due to non-fatal injury. The rate has decreased over the previous four years; but it increases when there is an outbreak. The prevalence of bullying and the attempts
for suicide indicate a need to address suicide, violence and bullying among adolescents. The overall percentages of adolescents performing physical activity and receiving well visits are very low.

**Programmatic Efforts**

**Continued Efforts:**

- American Samoa has successfully implemented its wellness activity in the Department of Public Health and the MCH program had implemented its nutrition program talks inside the school lunch program. MCH nutrition team would conduct talks relating to nutrition and physical activities during lunchtime for the various public schools.

- The Office of Highway safety patrol and the MIECHV program have work closely to administer child safety car seats to prevent injury during motor vehicle accidents and have conducted training for MCH Title V and MIECHV staff.

**Opportunity Efforts**

- Developmental screenings are successfully conducted within the MIECHV program which is under the MCH Division, but there is opportunity to increase this reach and promote screenings for children not using the public health system.

**Children and Youth with Special Health Care Needs (CYSHCN)**

**Transition to Adulthood**

The percentage of CYSHCN receiving services needed to transition to adulthood in American Samoa was less than the national average in 2009/10 (0% compared to 40.0%). For the past five years, no services of transitioning these youths to adulthood have been conducted as by the time the CYSHCN reaches their teen years, they got lost somewhere in the system and mostly there were no follow up at all. In 2014, the number of CYSHCN served were 8 times more than in the past 5 years. From those who were served on the program in 2014, only 2 out of the total number of CYSHCN served were ready to transitioned out adulthood and the CYSHCN team worked closely to assist the youth and family in making transition over to adulthood possible.

**Medical Home**

In 2009/10, 20% of the CYSHCN received care within a medical home compared to 43.0% nationally. Then in 2011/12, 79.5% received care within a medical home exceeds nationally. In 2013, 51.2% received care within a medical home. But this percentage is based only on a few number of CYSHCN and not on the majority of this population. The disparity exists where only a few are served and not all or majority. In 2014, 331 CYSHCN were served which is 8 times more than the number of CYSHCN that were served in the past 5 years and 78.2% of them remained on the program that needed continuous care and 21.8% were discharged from program for various reasons such as: moved off island, had enough support from families, no longer in need of services, etc. The 78.2% currently are active in the program have continued to receive care within a medical home compared to the previous 5 years.

**Qualitative Findings**

**Table 7. CYSHCN Qualitative Findings**

<table>
<thead>
<tr>
<th><strong>FOCUS GROUPS: CYSHCN HEALTH</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual – level Factors</strong></td>
</tr>
<tr>
<td>*Lack of knowledge about services</td>
</tr>
<tr>
<td>*Poor communication between parents and</td>
</tr>
<tr>
<td>providers</td>
</tr>
<tr>
<td>*Lack of transportation</td>
</tr>
<tr>
<td>*Families are responsible for care coordination</td>
</tr>
<tr>
<td>*Concern over transition to adulthood</td>
</tr>
<tr>
<td>*Lack of providers to see this population</td>
</tr>
<tr>
<td>*Bullying</td>
</tr>
<tr>
<td>*Culture’s view on</td>
</tr>
</tbody>
</table>

| Structural – level Factors                      |
| *Lack of support system                        |
| *Lack of centralized resource center           |
| *Transportation challenges & lack of appropriate vehicles to cater with this type of population. |
| *Lack of professional health care providers     |
| *Poor customer service                         |
| *Lack of employment opportunities for CYSHCN resources to aid with transition |
| *Culture                                       |

| KEY INFORMANT INTERVIEWS                        |
| Priority Needs                                 |
| *Physical Activity                            |
| *Awareness                                    |
| *Lack of services in the remote islands of Manu’a (Ta’u & Ofu) |

| Individual – level Factors                     |
| *Lack of motivation from peers                |
| *Lack of support from families                |
| *Culture                                      |
| *Lack of Finances                             |

| Structural – level Factors                     |
| *Lack of access to clinics                    |
| *Inaccessible facilities                      |
| *Lack of professional provider (pediatricians, nurses, etc.) |
| *No children’s visits conducted after 18 months. |
| *Lack of health coverage                      |
| *No leveraging of services                    |
| *Poor customer service                        |
Strengths and Needs

American Samoa exceeded national averages for CYSHCN receiving services within a medical home in 2011/12. However, it is only based on a few number of CYSHCN and not majority of the population. An effort to ensure that more CYSHCN are receiving the services needed to transition to adulthood is needed. American Samoa’s CYSHCN fall below the national average and experience larger gaps than what is seen at the local level.

Programmatic Efforts

Continued Efforts:

- The CYSHCN team was currently formed as of December 2014 and has been doing great work since they implemented services. The team consists of a supervisor, a field worker and a caseworker and a CYSHCN provider.

Opportunity Efforts:

- There is opportunity to increase services available for CYSHCN within the Territory to transition them to adulthood and to promote a transition clinic for this population.

Cross-Cutting / Life Course

Smoking during Pregnancy

From 2009 to 2012, the percentage of mothers who smoked during pregnancy remained steady at about 2.0%. In 2013, the percentage decreased to 1.7% but remained lower than the national average of 8.5%. The percentage of Samoan mothers who smoke during pregnancy is about 4 times lower than the state average.

Second Hand Smoke Exposure

In American Samoa, based on a survey conducted in regards to second hand smoke exposure, survey conducted more than 70% have been exposed to second hand smoking either at work, home, on the bus, at a restaurant, in the bathroom, at school. More than 50% of those surveyed live with at least one smoker and at least 95% of those have at least one friend who smokes. Smoke Free Act was passed by Legislature; however, it has not been enforced, as it should be.

Dental Visits during Pregnancy

In 2014, 67.7% of American Samoa pregnant women either had at least one prenatal visit at the community health centers. Out of the 67.7%, only 12.2% of them had their teeth cleaned during pregnancy.

Childhood Dental Visits

Within American Samoa, the disparity for childhood dental visits is within the Samoan race itself. 16.9% children had one or more preventive dental care visits (check up and cleanings). Majority of the children would not come in until they’re in pain or their tooth/teeth are too late to be saved.

Health Insurance

American Samoa does not have health insurance coverage except for Medicaid in which 87% of the people (excluding tourists and non-residents) of the Territory are covered. American Samoa utilizes a system of “presumed eligibility” meaning that each year the percentage of the population below 200% of the poverty level is estimate and, after approval of the estimate, CMS pays expenditures for Medicaid based on that percentage. Though majority of the people are paying the facility cost of $10 when seeing the doctor at the health centers and $20 at the LBJ Tropical medical center, and those fees does not include medications and lab tests which still makes it difficult for the people to pay.
Qualitative Findings

Table 8. Cross-Cutting /Life Course Qualitative Findings
<table>
<thead>
<tr>
<th><strong>FOCUS GROUPS: CROSS-CUTTING/LIFE COURSE HEALTH</strong></th>
</tr>
</thead>
</table>
| **Individual – level Factors** | *Lack of knowledge in oral health of adolescents  
*Lack of knowledge in perinatal oral health  
*Poor communication between parents and providers  
*Lack of transportation  
*Lack of insurance coverage  |
| **Structural – level Factors** | *Lack of support system  
*Lack of centralized resource center  
*Transportation challenges & lack of appropriate vehicles to cater with this type of population.  
*Lack of professional health care providers  
*Poor customer service  
*Lack of methods utilized for tobacco cessation  |

<table>
<thead>
<tr>
<th><strong>KEY INFORMANT INTERVIEWS</strong></th>
</tr>
</thead>
</table>
| **Priority Needs** | *Lack of knowledge in oral health of adolescents  
*Awareness  
*Lack of services in the remote islands of Manu’a (Ta’u & Ofu)  |
| **Individual – level Factors** | *Lack of motivation from peers  
*Lack of support from families  
*Culture  
*Lack of Finances  |
| **Structural – level Factors** | *Lack of access to clinics  
*Inaccessible facilities  
*Lack of professional provider (pediatricians, nurses, etc.)  
*No children’s visits conducted after 18 months.  
*Lack of health coverage  
*No leveraging of services  
*Poor customer services  |
**Strengths and Needs**

American Samoa has shown improvements regarding tobacco use. The percentage of children exposed to second hand smoke is high. Additionally, the percentage of women smoking during pregnancy in American Samoa remained below the national average of 8.4% in 2013. Children receiving a preventive dental visit remains very low. There is a disparity among pregnant women receiving dental care. No health insurance coverage is another area of need. Economic disparity exists and needs to be addressed.

**Programmatic Efforts**

**Continued Efforts**

- The MCH School Dental Team has continued to see children in schools and have worked to expand seeing other age groups rather than just 3rd – 5th graders. It has added additional staff so that team can see more children and provide fluoride varnishing at the schools during their sessions and then provide fluoride varnishing at the WIC office and at the community health centers.

- MCH staff will educate women and children on the Smoke Free Environment Act so that there will be lesser people expose to second hand smokers.

**Opportunity Efforts**

- There is opportunity to develop an oral health resource database for CYSHCN to increase preventive visits in this population and also to all the children of the Territory.

**II.B.2.b Title V Program Capacity**

**II.B.2.b Title V Program Capacity**

More on Title V Program Capacity also on Comprehensive Needs Assessment.

**II.B.2.b.i. Organizational Structure**

**II.B.2.b.i. Organizational Structure**

The American Samoa’s Department of Public Health (DPH) or Department of Health (DOH) (terms are interchangeable) administers the Title V Block Grant. DPH/DOH is the lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a public health perspective. The Director of Health is elected by the Governor and the Director reports directly to the Governor.

The Maternal and Child Health Section (MCH) is under the direction of the Director of Nursing. The Director of Nursing also oversees the following programs: Nursing Home visit, Part C/Helping Hands, Immunization, Breast and Cervical Cancer and Tobacco/Diabetes program. The MCH Division consists of the Title V Block Grant, State System Development Initiative Grant and the Maternal, Infant and Early Childhood Home Visiting Program in which a Division Head manages these 3 programs. The program manager is the MCH Director and the Title V Program Coordinator is the CSHCN Director.

In 2014, MCH began a restructure to provide better coordination across programs. The restructure is expected to be completed by September 2015. There are various services under the MCH Division: Children with Special Health Care Needs, Aiga Manuia Home Visiting Program, Dental School Program, Rheumatic Heart Disease Program, Nutrition, Data Team, Quality Assurance and State System Development Initiative. All services are part of the outreach team to the community. The purpose of restructuring is to make better the linkage of services from one area to the other.
The American Samoa Title V Program does not fund any other programs; however, it funds providers and nurses for prenatal services and children’s services. It also funds some support staff in the clinics to assist with client appointments follow up and reminders.

Title V collaborates with a lot of non-governmental organizations (NGO) so that services are promoted in the communities of American Samoa. The Title V program works closely with the Family Planning Program, American Samoa’s Alliance for Strengthening Families, Aiga Manuia Home Visiting Program, Toe Afua Mai Matua Samoa (Mentors for children by Senior Group) and faith-based organizations and government agencies.

Family Planning improves the health of women and infants by enabling families to plan and space pregnancies and prevents unplanned pregnancy; however, it is only available in one location which is at the LBJ Tropical Medical Center.

Newborn Screening (NBS) have not been implemented in American Samoa yet.

MCH’s School Dental Team provides community fluoride varnishing to children ages 7-11, dental sealants and dental health education; however, has expanded services to high school students when requested by teachers or school principal.

Aiga Manuia Home Visiting program enrolls pregnant women in American Samoa to have every opportunity access comprehensive perinatal health care services appropriate to meet their individual needs and supports outreach efforts in the whole Territory. Perinatal health also addresses infant mortality and breastfeeding.

Universal Newborn Hearing Screening for hearing loss are done in the birthing hospital and links infants to appropriate intervention.

II.B.2.b.ii. Agency Capacity

MCH has continuously work on building its capacity (structural resources, data systems, partnerships and competencies) to provide Title V services to the following domains: maternal/women’s health, perinatal health, child health, CYSHCN and oral health. Since there are no adolescent health programs, MCH is now required to address the needs of this population. In each domain, MCH has initiated partnerships with external organizations, which are to ensure a local system of services that are comprehensive, community-based, coordinated and family centered.

Maternal/Women’s Health

MCH uses Title V funds to provide services for women of reproductive age. The Family Planning Program is under the LBJ Tropical Medical Center and is not available at the community health clinics. Family planning clinic is supported by Title X. MCH actively supports all the preventive health programs and will engage in various initiatives to promote maternal health, including the Smoke Free Initiative. MCH has data staff in addition to the epidemiology staff to support programmatic efforts. Data sources used are PRAMS, Vital Records, BRFSS, Pre-Natal Services Survey and Family Planning program data.

MCH has active partnerships with hospitals, private practice physician, Breast and Cervical Cancer Program and HIV screening programs, and Diabetes & Tobacco Cessation to ensure a comprehensive system of services for women of reproductive age in American Samoa.

Perinatal/Infant Health

Title V staff supports newborn hearing screening, breastfeeding initiatives, preterm birth initiatives, perinatal regionalization and the Safe to Sleep campaign to promote perinatal health. MCH has a representative in the Fetal and Infant Mortality Review Committee to update MCH program of any fetal or infant death and what MCH could
assist in making better and to improve. MCH works closely with the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, which supports pregnant women. Title V supports data staff in addition to epidemiology staff to collect and analyze data on perinatal health. The primary data sources used are Vital Records and PRAMS. MCH has active partnerships with LBJ Tropical Medical Center Maternity Ward and OB-GYN Clinic, private practice physician, Association of State and Territorial Health Officials (ASTHO), Department of Human and Health Services (DHSS) WIC and Worksite Wellness.

Child Health

MCH promotes child health through the Well Baby Clinic and through the MIECHV program. MCH works closely with Part C - Helping Hands Program where children with developmental delays are referred to for developmental screenings. The MIECHV program also utilizes a developmental screening. MCH staff still needs training in developmental screening and the various tools used to assess developmental screening. The MCH program collaborates with the Department of Highway Safety Patrol to prevent motor vehicle accident deaths among children. When MCH recognizes a child in need of a car seat, they are referred to the Department of Highway Safety Patrol for an education on the car seat before they are given one. MCH program promotes physical activity in the Well Baby Clinics and also out in the schools. Title V supports the work of these various activities, however they rely on additional funding sources as well.

To ensure a comprehensive system of services among children, MCH has active partnerships with Department of Education (DOE), Department of Youth and Women’s Affairs (DYWA), and Well Baby Clinics at the community health centers.

Adolescent Health

There is no program dedicated to adolescent health within MCH. MCH will work on this area for the next five years.

CYSHCN

MCH supports several programs to provide services to American Samoa’s CYSHCN. Title V has CYSHCN teams that conduct visits and follow up visits for CYSHCN and link them to other available services. Part C / Helping Hands serves children with disabilities.

To ensure a comprehensive system of services among CYSHCN, MCH has active partnerships with the LBJ hospital, private practice physician, and the Department of Education.

Oral Health

MCH has Title V to support oral health initiatives. MCH has access to oral health data through its school dental team and dental services survey. The Oral Health program does not have an Oral Heath Epidemiologist; however, it’s a need for the program.

To ensure a comprehensive oral health system of services, MCH has active partnership with WIC, Community Health Centers Dental Clinics and the Department of Education.

II.B.2.b.iii. MCH Workforce Development and Capacity

Description

There are currently 34 FTEs working on behalf of the Title V program in American Samoa.

MCH Leadership Staff
Motusa Tuileama Nua, is the Director of the Department of Health. He is the Principal Investigator for the Maternal and Child Health Funds.

Margaret Sesepasara, NP, MSN, RN, BSN is the Maternal and Child Health Director.

Aileen E. Solaita, is the Maternal and Child Health Division Head. She oversees the MCH Division, which includes Title V, SSDI and MIECHV. She is responsible for overseeing all operational functions of MCH, including grants. Works with senior Department of Health Leaders, other Government Agency leaders and stakeholders to define and implement MCH strategic direction, monitor progress and compliance against the strategic plan.

Jacinta Tialavea, is the Title V Program Coordinator who is responsible for the managing and coordinating of the day to day operations. Works closely with staff and conducts training for staff. She also oversees the CYSCHN program.

Iutita Snow, is the CYSHCN Supervisor. She supervises the CYSHCN 3 teams which consists of a caseworker and a fieldworker in each team.

Tele Hill, is the Nurse Practitioner that conducts prenatal care in the prenatal clinics. She is also the provider for CYSHCN.

Anaise Uso, is the Dentist that is supervising the Dental School Outreach Team. She is responsible to train dental staff and conduct fluoride varnishing and fissure sealants for children (7—11 years of age).

Susan Valoaga is the State System Development Initiative Coordinator and works closely with the Title V and MIECHV programs.

Vasati Ieremia is the Quality Assurance Manager for the MCH Title V and MIECHV program.

**Strengths and Needs of Workforce**

Fifteen (15) percent of the state Title V staff has been in MCH for fewer than 5 years. The other 15% have served for more than 20 years and 70% for less than 2 years.

A survey was disseminated to state, district and local DPH/DOH employees providing MCH services to assess the strengths and needs of the workforce. Results indicate that training efforts should be targeted toward the following public health competencies: leadership and systems thinking, management skills, workforce development and continuous training for workforce competency.

**Cultural Competence**

Several methods are used to ensure culturally competent approaches. These methods are used in service delivery across all MCH programs. MCH Data Team collects and analyzes data by race/ethnicity and income to assess health equity and inform program activities. Most staff are bi-lingual, but speaks the native tongue more than English as English is a second language for majority of our Territory. Focus groups and key informant interviews were conducted among Samoan families for Title V.

MCH works closely with community leaders to plan service delivery programs, collaborate on grants and implement culturally competent services that meet the unique needs of populations. Leaders of organizations targeting culturally diverse groups partner with our programs. New Born Screening (NBS) has not been implemented in American Samoa. The MCH Manager, the LBJ Pediatrician, and the Newborn Hearing Screening Manager are working on the plan for NBS.

In all MCH programs, services and/or educational materials are provided in English and Samoan. The Dental School
Outreach program has bilingual staff that will provide outreach education targeted to Samoan children.

II.B.2.c. Partnerships, Collaboration, and Coordination

American Samoa maintains partnerships to build the capacity of MCH services in the Territory and also nationally.

**MCHB investments:** American Samoa receives MCHB investments through Maternal, Infant and Early Childhood Home Visiting, Healthy Start. The Title V program partners with the MIECHV program. State Systems Development Initiative is also utilized to assist with Title V Data collection.

**Other federal investments:** There are no other federal investments except for the ones from MCHB.

**Other HRSA programs:** District coordinators partner with Federally Qualified Health Centers.

**State and local MCH programs:** The state Title V program is under the MCH program that is under the local Department of Health.

**Other programs within the Local Department of Health:** MCH partners with several other sections in the Department of Health: MCH partners with Immunizations, Vital Records, Diabetes /Tobacco Cessation, HIV and STD Prevention, Environmental Health, Part C – Helping Hands, Early Hearing Detection Initiative (New Born Hearing Screening), Epidemiology, Breast and Cervical Cancer, Cancer Comprehensive Control, and the Community Health Centers.

**Other governmental agencies:** MCH has strong relationships with the Department of Human and Health Services, Department of Public Safety, Department of Education, Department of Youth and Women’s Affair and the Office of Vocational Rehabilitation.

**Public health and health professional educational programs and universities:** MCH partners with the local American Samoa Community College (ASCC). ASCC provides a Certificate in Public Health, Certificate in Nursing Assistant and also English as a Second Language for the MCH workforce.

**Others:** MCH has a representative on the Fetal and Infant Mortality Review Committee. MCH participates in the CoIIN Initiatives.

**Family/Consumer Partnerships**

**Diversity**

A diversity of families were engaged in Block Grant activities. Parents of CYSHCN and several community members attended the stakeholder meetings. These participants primarily had formal knowledge of MCH issues. The focus groups conducted for the needs assessment included parents from every public health district and various racial groups. Focus groups were conducted in bilingual - English and Samoan.

Only family/consumer in CYSHCN and MIECHV receive compensation. Families that participate in the Focus Groups were compensated with gas vouchers and a gift certificate for grocery to attend the meeting.

MCH is currently planning curriculum for families. Family Leadership Training, Public Health 101 and MCH 101 will be the first trainings conducted. Trainings on Title V and cultural competency will also be included.

**Evidence and range of issues being addressed through the family/consumer partnership**

Family/consumer partners primarily provide insight into the types of needs they are facing, and how the programs can best address them. Through participation in advisory councils, they impact all activities. In the MIECHV and CYSHCN project, parents are providing emotional support, linkages to community resources, transition to adult health care education and assistance with navigating the health care and special education systems.
**Impact of family/consumer partnership on programs and policies**

Family/consumer partnerships have impacted programs and policies in several ways. They directly participate in planning through advisory councils. However, there are indirect impacts as well. A survey of program managers and directors showed that established family/consumer partnerships have enabled them to better understand what is relevant to the populations they are serving and the types of family issues involved.

**Description of the state’s efforts to build and strengthen family consumer partnerships for all MCH populations**

Families are recruited through a variety of methods, including those who use the services, pediatricians, schools, workshops, health fairs, word of mouth, non-profit agencies and committees. It is intended that several of the families that were engaged for the needs assessment will continue to be engaged throughout the reporting cycle.

Trainings are currently being developed for families of CYSHCN to empower them to provide input on policies and program activities, as well as Block Grant activities.

Program managers were surveyed to determine their perceptions pertaining to the importance of family/consumer partnerships and the barriers they face. Although all respondents expressed the input they receive is crucial to effective program planning, they identified several barriers to engaging families and consumers, including the additional pressure to deliver more than is feasible, lack of father participation, keeping families involved, constraints of time and meeting location and having an ongoing funding source. These results will be used to engage with programs on how to best engage families and consumers throughout all programs.
### II.C. State Selected Priorities

<table>
<thead>
<tr>
<th>No.</th>
<th>Priority Need</th>
<th>Type</th>
<th>Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)</th>
<th>Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Increase Breastfeeding babies at 3 months and 6 months of age.</td>
<td>Continued</td>
<td>Perinatal/Infant's Health</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Reduce infant mortality rate.</td>
<td>New</td>
<td>Perinatal/Infant's Health</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Reduce Childhood Obesity.</td>
<td>Continued</td>
<td>Child Health</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Promote oral health in all 6 domains.</td>
<td>Continued</td>
<td>Life Course/Cross Cutting</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Improve system of care for CYSHCN.</td>
<td>Continued</td>
<td>CYSHCN</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Promote evidence based developmental screenings for children 0-5 years of age.</td>
<td>New</td>
<td>Child Health.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Increase Access and Awareness to Adequate Prenatal Care.</td>
<td>Continued</td>
<td>Women's/Maternal Health</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Reduce Acute Rheumatic Fever and Rheumatic Heart Disease.</td>
<td>New</td>
<td>Life Course/Cross Cutting</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Increase Immunization Coverage Rates.</td>
<td>Continued</td>
<td>Adolescent</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Prevent adolescents from being bullied or bullying others.</td>
<td>Continued</td>
<td>Adolescent Health</td>
<td></td>
</tr>
</tbody>
</table>

### II. C. State Selected Priorities

**Selection Process**

American Samoa used the following definition for a priority need: a gap in the health status of the population due to trend or disparities that can reasonably be addressed by the Title V program in which stakeholders have demonstrated strong interest in or support of. In order to select priorities out of all needs identified through the assessment, stakeholders were asked to rate needs identified in the assessment by MCH staff at the Stakeholder Meetings. Results from the meetings were treated as a recommendation and the ultimate selection of priority needs was determined by MCH leadership to ensure the selected needs were best addressed by the Title V program. In determining final priorities, primary weight was given to the Stakeholder Meeting results but findings from the quantitative analysis, focus groups, key informant interviews, surveys, public comment period and the capacity assessment were considered to validate findings. Most NPMs were considered as priority needs at the Stakeholder Meetings. In most instances, the NPMs further informed the selection of the priority need they impact. When
appropriate, the NPM became priority needs.

Needs Strongly Considered

Table 1 presents the results from the Stakeholder Meetings. Participants rated each need from 1-5 based on six criteria: seriousness of the issue, health equity, economic impact, trend, magnitude of the problem and importance. Weights were applied to the criteria as follows: 3 for seriousness of the issue, 3 for health equity, 2 for economic impact, 1 for trend, 2 for magnitude and 1 for importance. Ratings for each criterion were averaged, multiplied by their weight, and added together to determine the final rating score for each priority need. Out of the 45 priorities that were identified, the list was narrowed down to 20 and then from there the stakeholders selected the top priorities. Below is the narrowed list which is not in any specific order, but priorities have been selected as identified by an (*).

Table 1: Priority Need Narrowed to 20 from the list of 45.
1. Prevent Maternal Mortality

Preventing maternal mortality is vital to improving the health of women in the state. Both quantitative and qualitative data examined in the Needs Assessment indicated the need to prevent maternal mortality in American Samoa. American Samoa’s maternal mortality ratio decreased from 14.1 (n=18) in 2010 to 4.7 (n=6) in 2011, it increased to 9.4 (n=11) in 2012 and doubled the ratio to 18.1 (n=21) in 2013. Additionally, American Samoa in 2006 had the highest ratio of 20.8 (n=30) in 2006. Interviews with leaders in the field recommended this priority. Preventing
maternal mortality was also a clear priority of stakeholders involved in the Needs Assessment. Maternal mortality was rated highest in the maternal/women’s health domain at the Stakeholder Meetings and ranked 1st overall. Promoting well-woman visits, a related NPM, was the highest rated NPM in this domain at both the Stakeholder Meetings and through a survey completed by stakeholders.

2. Reduce infant mortality

Reducing infant mortality is a clear need that came out of the Needs Assessment. Though the preferred goal is to prevent infant mortality; however, that is impossible with the statistics of prenatal care and with only one hospital for deliveries, the selected priority was reworded to “Reduce Infant Mortality.” Quantitative analysis showed that American Samoa’s infant mortality rate decreased from 14.9 in 2010 to 7.0 in 2011, then again decreased to 3.4 in 2012 but it increased again to 4.3 in 2013. Strong disparities are present and should be addressed to achieve health equity. Although preventing infant mortality was identified at the Stakeholder Meetings, factors impacting infant mortality were considered. Low birth weight and preterm deliveries were also ranked needs closely to preventing infant mortality. So stakeholders strongly supported to address the overarching issue of infant mortality by reducing it instead of preventing it. Although breastfeeding, perinatal regionalization and safe sleep received lower ratings, quantitative analysis revealed that American Samoa needs to make significant improvements to be comparable to national averages and achieve Healthy People 2020 goals to reducing infant mortality. Strong community support to address breastfeeding was displayed throughout the public input period.

3. Reduce Childhood Obesity

Given the prevalence of obesity in American Samoa and low percentages of children performing recommended amounts of physical activity, promoting physical activity was selected as a state priority. Physical activity was the highest ranked priority in the child health domain.

4. Promote Development Screenings Among Children.

Given that New Born Screenings is not conducted in American Samoa and the number of children not prepared for high schools and high schools students not ready for College, this screening is very much needed. There is great room for improvement. This priority was not really rated high at the stakeholders meetings; however, through surveys and public input and especially from the workforce who deals with children, it was show that this is a need that needs to be addressed.

5. Improve systems of care for CYSHCN

Data examined during the Needs Assessment identified several areas where the system of care for CYSHCN should be improved. Therefore, this priority need was phrased to reflect the need to improve the overarching system that families engage with. Data from qualitative data revealed that families are not aware of existing services, provide their own care coordination and medical home, lack access to specialty providers and do not feel prepared to transition to adulthood.

6. Prevent being bullied or bullying others.

Being bullied by others or bullying others is very prevalent in the children of American Samoa. Though not much data is collected on this concern; however, it has been ranked by parents and families involved in the needs assessment.

7. Promote adolescent health.

Adolescent health is not taken seriously by the local department of health clinics but it has been ranked high also by families and surveys that were conducted in the community.

8. Promote oral health among all population.

Both quantitative and qualitative data examined support the selection for improving health as a priority need.
Disparities were noted in women receiving dental care during pregnancy and an overall decline in the percentage of children receiving a dental visit. A particular lack of access to oral health services for CYSHCN was identified through key informant interviews. Throughout the needs assessment, strong community support for this need was demonstrated through the public input period.

**Priority Comparison**

The current priority needs were identified through a new vision and framework and are therefore not a direct continuation of priority needs from the previous reporting cycle. However, several similarities between the two sets of priority needs should be noted. Table 2 presents a comparison of these similarities and differences between priority needs for 2010-2015 and 2016-2020.

<table>
<thead>
<tr>
<th>#</th>
<th><strong>2011-2015</strong></th>
<th><strong>2016-2020</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Increasing immunization coverage for young children.</td>
<td>No similar need. (Priority replaced)</td>
</tr>
<tr>
<td>2</td>
<td>Increasing adequacy of prenatal care for pregnant women.</td>
<td>Prevent maternal mortality. (Priority continued)</td>
</tr>
<tr>
<td>3</td>
<td>Improving BMI of children 2-5 years old.</td>
<td>Reduce childhood obesity (Priority replaced)</td>
</tr>
<tr>
<td>4</td>
<td>Improving nutritional status of 1 year olds.</td>
<td>No similar needs. (Priority replaced)</td>
</tr>
<tr>
<td>5</td>
<td>Increase the number of infants who are breastfed.</td>
<td>Reduce infant mortality. (Priority replaced)</td>
</tr>
<tr>
<td>6</td>
<td>Improve oral health children 0-5 years.</td>
<td>Promote oral health among all populations. (Priority continued)</td>
</tr>
<tr>
<td>7</td>
<td>Improve services for Children with Special Health Care Needs.</td>
<td>Improve systems of care for CYSHCN. (Priority continued)</td>
</tr>
<tr>
<td>8</td>
<td>No similar need.</td>
<td>Promote development screenings among children. (Priority added)</td>
</tr>
<tr>
<td>9</td>
<td>No similar need.</td>
<td>Prevent being bullied or bullying by others. (Priority added)</td>
</tr>
<tr>
<td>10</td>
<td>No similar need.</td>
<td>Promote adolescent health. (Priority added)</td>
</tr>
</tbody>
</table>

Promote oral health among all populations was identified as a priority in both assessments except the years are to include adolescents and youths for 2016-2020. Improve systems of care for CYSHCN was also identified in both assessments and is still considered an area that needs much improvement. The other priorities from the previous needs assessment had similar need for 2016-2020 and they include prevent maternal mortality, reduce childhood obesity, and reducing infant mortality. The new selected priorities that were not identified in the past needs assessment include: promote development screenings among children; prevent being bullied or bullying others, and promoting adolescent health.
II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

NPM 3-Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>50.0</td>
<td>49.0</td>
<td>48.0</td>
<td>47.0</td>
<td>46.0</td>
</tr>
</tbody>
</table>

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>1.0</td>
<td>5.0</td>
<td>10.0</td>
<td>15.0</td>
<td>20.0</td>
</tr>
</tbody>
</table>

NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

NPM 9-Percent of adolescents, ages 12 through 17, who are bullied or who bully others

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>80.0</td>
<td>60.0</td>
<td>40.0</td>
<td>20.0</td>
<td>10.0</td>
</tr>
</tbody>
</table>
II. D. Linkage of State Selected Priorities with National Performance and Outcome Measures

The priority needs identified by the state based on the findings of its Five-year Needs Assessment has linked to the following national performance and outcome measures.

Out of the 15 national performance measures that are provided in the guidance under Appendix F, the American Samoa MCH has identified the top eight (8) national performance measures to be addressed over the five-year period in the Title V program. These selected eight (8) national performance measures were based on their relevance to factors related to priority needs, as well as considering the national outcome measures they impact. The selected national performance measures and related priority are displayed below. All of the priority needs have been associated with a national performance measure.
<table>
<thead>
<tr>
<th>#</th>
<th>PRIORITY NEED</th>
<th>DOMAIN</th>
<th>NATIONAL PERFORMANCE MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prevent maternal mortality</td>
<td>Women / Maternal Health</td>
<td>Well woman visits</td>
</tr>
<tr>
<td>2</td>
<td>Reduce infant mortality</td>
<td>Perinatal / Infant Health</td>
<td>Perinatal Regionalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Breastfeeding</td>
</tr>
<tr>
<td>3</td>
<td>Reduce childhood obesity.</td>
<td>Child Health</td>
<td>Physical</td>
</tr>
<tr>
<td>4</td>
<td>Promote development screenings among children.</td>
<td>Child Health</td>
<td>Developmental screenings</td>
</tr>
<tr>
<td>5</td>
<td>Improve systems of care for CYSHCN</td>
<td>CSHCN</td>
<td>Medical Home</td>
</tr>
<tr>
<td>6</td>
<td>Prevent being bullied or bullying others.</td>
<td>Adolescent Health</td>
<td>Bullying</td>
</tr>
<tr>
<td>7</td>
<td>Promote adolescent health.</td>
<td>Adolescent Health</td>
<td>Adolescent well visit</td>
</tr>
<tr>
<td>8</td>
<td>Promote oral health among all populations.</td>
<td>Cross-Cutting / Life Course</td>
<td>Oral Health</td>
</tr>
</tbody>
</table>

Below are the rationales of why the 8 national performance measures have been selected and part of the determination of these NPMs are also based on surveys that were conducted via on-line and face to face to determine inputs from stakeholders and community feedback.

1. **NPM#1:** Increase the percentage of women with past year preventive medical visit. (Woman & Maternal Health Domain)

Priority Need: Prevent maternal mortality.

Rationale: It was ranked higher than the 2 measures under Woman/Maternal Health. Based on the 2016-2020 Needs Assessment and public input, this NPM has been ranked as #1. Also based on the Kotelchuck index cards, though Adequate PNC is 29.5%, A+ PNC at 22.0%, inadequate prenatal care at 28% and the rest with very poor prenatal care or no prenatal care at all. Additionally, majority of women before entering pregnancy are obese and have diabetes. It is essential that American Samoa ensure women are healthy prior to entering pregnancy through promoting well-woman visits among women of reproductive age. Although the percentage of women have increased where they are seeing a physician, however, it doesn't guarantee that they are fulfilling their prenatal care visits.
Health Education and Home visiting done at the LBJ Maternity Ward, OB-GYN clinics, at the community health center clinics are essential to promoting preconception and interconception care for women. Not only do well-woman visits promote the overall health of women through the life course, perinatal health is impacted by preventing low birth weight and preterm births. Though these outcomes do not relate directly to the priority needs, these are important measures to address in American Samoa and it should be encouraged by promoting well-woman visits so that these outcomes will be impacted as well.

2. NPM#3: Decrease the percentage of very low birth weight infants born in a hospital with a Level II+ Neonatal Intensive Care Unit.

Priority Need: Reduce Infant Mortality.

Rationale: Perinatal regionalization was selected to address infant mortality. Low birth weight and very low birth weight is a common cause of infant mortality. Although these births should be prevented, it is essential to put systems in place to ensure that appropriate care is given to these infants when VLBW births do occur. Due to the high percentages of infants born preterm and at low birth weight in the Territory, it is imperative to identify these infants early and ensure that they receive care to prevent mortality among these infants. Infants born in a facility with a NICU and with staffing that can accommodate their needs gives them a higher likelihood of survival and reduces infant mortality. There is room to improve the perinatal regionalization system in American Samoa and ensure that mothers and infants are born in a facility that provides the most appropriate level of care for their level of risk. There is room to improve the system even if there is only one birth facility on the island.

3. NPM#6: Increase percentage of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool. (Child Health Domain)

Priority Need: Promote developmental screenings among children.

Rationale: It was ranked the 2nd highest from the 2 measures as identified under Child Health Domain. Based also on the 2016-2020 Needs Assessment and public input, this NPM has been ranked as #8. This NPM has been identified as the 8th out of the 15 NPM that is important to be considered for the next five years. Because the Territory of American Samoa does not conduct newborn screenings, this NPM has been selected to recognize children who are in need of such assistance early in the first years of life to prevent a more serious condition that could have been prevented earlier. With this NPM, those who have identified earlier in life to have developmental delays can be referred to the proper services that can provide the necessary services.

4. NPM#8: Increase the percentage of children ages 6 through 11 who are physically active at least 60
minutes per day. (Child Health Domain)

Priority Need: Reduce obesity in children.

Rationale: It was ranked higher from the 3 measures as identified under Child Health. Based also on the 2016-2020 Needs Assessment and public input, this NPM has been ranked as #2. Because obesity is prevalent in the islands of American Samoa, and it’s a risk factor of non-communicable diseases, it is vital for the MCH program to encourage physical activity and implement activities that can increase the number of children to be physically active. Disparities are present by income. It is essential to address this performance measure in order to impact overweight and obesity among children. It is intended that by promoting positive behaviors early in life, they will continue into adolescence and adulthood to prevent obesity and the prevalence of chronic disease in the population. Promoting physical activity promotes the overall health of children, even in the absence of chronic diseases.

5. NPM#11: Decrease the percentage of adolescents ages 12 through 17, who are bullied or who bully others.

Priority Need: Prevent suicide among adolescents.

Rationale: It was ranked high on the 4 measures identified for Adolescent health. Though it is not reported; however, it has been identified by families/parents involved in needs assessment that it is an issue that should be taken into consideration as it has affected their children psychologically, mentally and socially. Victims of bullying often become bullies themselves engaged in a negative cycle. Addressing bullying prevent suicide, it also promotes overall health by preventing feelings of depression and associated behavior, including violence. Electronic bullying is an area that should be examined throughout the five year reporting cycle as well, as social media usage continues to increase among adolescents. Data examined in the needs assessment showed that American Samoa’s teens frequently engage in violent behaviors such as fights in schools and bullying via social media.

6. NPM#12: Increase percentage of adolescents ages 12 through 17, with a preventive medial visit in the past year.

Priority Need: Promote adolescent well visits.

Rationale: This NPM# was ranked 2nd highest out of the 4 measures identified for the adolescent health as obesity and other non-communicable diseases are prevalent in American Samoa. Addressing this issue is essential for the future of American Samoa and prevention is the key to a lot of chronic diseases. Implementing adolescent well visits can have a great impact on the outcome of adolescent health if they are done continuously. Providing support and education for adolescents to understand the outcome of being healthy and staying healthy can
7. **NPM#13**: Increase the number of adolescents with and without special health care needs having a medical home.

**Priority Need:** Improve systems of care for CYSHCN.

**Rationale:** It was ranked higher from the 2 measures as identified under Children with Special Health Care Needs. Based also on the 2016-2020 Needs Assessment and public input, this NPM has been ranked as #3. The Needs assessment team together with feedbacks from parents have identified there is a major lack of physicians that are comfortable in serving children with special health care needs. Implementing initiatives that can increase this NPM and the needs assessment team have expressed the unfairness of CSHCN are not being provided the same opportunity as normal children.

The issue is of increasing significance, as children with special health care needs are lacking the care they need compared to normal children and youth. Fewer children and youth in American Samoa are receiving the services needed due to finances, culture, lack of support and not knowing what actual services are available for this population.

8. **NPM#15**: Increase percentage of children, ages 1 through 17, who had a preventive dental visit in the past year. (Cross-cutting/Life Course Domain)

*Increase percentage of women had a dental visit during pregnancy.*

*(Cross-cutting/ Life Course Domain)*

**Priority Need:** Promote oral health among all populaitons.

**Rationale:** It was ranked higher from the 5 measures as identified under Cross-cutting / Life Course Domain. Based also on the 2016-2020 Needs Assessment and public input, this NPM has been ranked as #4. Furthermore, based on the 2014 report for dental screenings and services provided by MCH for age group from 7 to 11 years where majority are 8 year olds (81.5%), a 82.8% of students had at least one tooth affected by dental caries. 73.2% of third graders screened had at least one baby tooth affected by decay and approximately 33% of third graders had decayed permanent teeth. With these data, the needs assessment team have decided to select this NPM as #4 for the 8 out of the 15 NPM.

There is a great need to encourage women who are pregnant to get a dental visit during pregnancy as oral health of
a pregnant woman can also affect the oral health of newborn.
II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

The five-year needs assessment is part of an on-going process. The priority needs identified by the state based on the findings of its Five-year Needs Assessment has linked to the following state performance and outcome measures.

Ten (10) stated selected priorities have been identified, 8 of the 15 national performance measures have also been identified and American Samoa MCH has selected the five state performance measures that it would like to consider in the next five reporting years.

The following state performance and outcome measures to be considered are as followed:

**SPM#1:** The percent of American Samoa’s children screened for Rheumatic Heart Disease.

Priority Need: Promote adolescent health

Rationale: This problem has been long forgotten in the developed world, but is an enormous cause of preventable disabilities and deaths among the young children in American Samoa. There is no formal RHD control program but there should be as children are suffering and dying needlessly from a preventable disease. This need has been identified locally for the Territory which is not a problem nationally but a major problem locally that are affecting the adolescents of American Samoa.

The following outcome measures that are associated with this state performance measure would include the following:

*NOM#16.1 – Adolescent mortality rate ages 10 through 19 per 100,000.

*NOM#19 – Percent of children in excellent or very good health.

This SPM is linked to national performance measure #2 – Increase the percentage of children ages 6 through 11 who are physically active at least 60 minutes per day and national performance measure #6 – Increase percentage of children ages 12 though 17 who are physically active at least 60 minutes per day.

**SPM#2:** The percent of children with special health care needs who are abused and neglected.
Priority Need: Prevent being bullied by others.

Rationale: There have been numbers of CSHCN that have been identified by the CSHCN team that are most likely neglected and abused by family members, but are not reported.

The following outcome measure that is associated with this state performance measure are as followed:
*NOM#15 – Child mortality rate ages 1 through 9 per 100,000.
*NOM#16.1 – Adolescent mortality rate ages 10 through 19 per 100,000.
*NOM#18 – Percent of children with a mental/behavioral condition who receive treatment or counseling.

SPM#3: The rate of sexual transmitted diseases for adolescents ages 13-17 years.

Priority Need: Promote adolescent health.

Rationale: Because of limited promotion of safe sex in the Territory due to a few people’s perspective that is taboo and culture sensitive, adolescents and youths most likely are experiencing sex no matter what.

The following outcome measures that are associated with this state performance measure is
*NOM#22.3 – Percent of adolescent ages 13 through 17, who have received at least one dose of the HPV vaccine.

SPM#4: The number of nurses stationed at primary and secondary public schools.

Priority Need: Promote adolescent health.

Rationale: Because of the rise of the influenza, dengue, chikungunya and other diseases, there have been discussions where a if a nurse is made available at the schools, it would prevent unnecessary ER visits.
The following outcome measures that are associated with this state performance measure include the following:

*NOM#15 – Child mortality rate ages 1 through 9 per 100,000.

*NOM#16.1 – Adolescent mortality rate ages 10 through 19 per 100,000.

**SPM#5:** The number of birth to age 3 served by an evidenced-based home visiting program.

**Priority Need:** Prevent maternal mortality.

**Rationale:** Because shortage of nurses and physicians which leads to lack of time available to educate parents and child in regards to issues and concerns relating to the child’s health, the leadership team and the needs assessment team have considered utilizing evidence based home visiting program to determine if there’s any improvement in child and parents in the child’s health.

The following outcome measures that are associated with this state performance measure include the following:

*NOM#9.1 – Infant mortality rate per 1,000 live births.

*NOM#9.5 – Sleep related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births.

*NOM#13 – Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL).

*NOM#15 – Child mortality rate ages 1 through 9 per 100,000.

The following NPM that are associated with this SPM include the following:

*NPM#5 – Increase number of infants who are ever breastfed and increase percentage of infants breastfed exclusively through 6 months.

*NPM#8 – Increase percentage of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.
II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

In 2015, the MCH program completed the needs assessment for MCH 2016-2020. The process involved the Department of Health (MCH/CSHCN, Immunization, Early Intervention Program, Part C Helping Hands, Tobacco, Non-communicable Disease, Community Health Centers, Nursing Program, MIECHV, SSDI Program), the DHSS programs -WIC, CPS, Substance Abuse Program, Child Care services, Foodstamp), VOC REHAB, DOE– (Guidance and Counseling Program, Juvenile Detention Center), and non-governmental organizations such as Flowers of Tomorrow, Alliance Against Domestic Violence, Toe Afua Mai Matua Samoa (Restoration through our Senior group), Grace Care Home, Vida Medical Clinic, and LBJ Tropical Medical Center. The MCH leadership team has made every effort to include all listed agencies above in the needs assessment and planning process. All played a vital role in the selection of the 10 priority needs for the Territory of American Samoa. This section provides an overview of American Samoa’s MCH 2016-2020 Action Plan to address the ten selected priority needs. The following narrative provides activities, accomplishments and challenges with the past performance measures as well as plans for the future on newly identified priority needs. The narrative is organized in the following orders:

- Accomplishments: October 1, 2013 to September 30, 2014
- Current Activities: October 1, 2014 to September 30, 2015
- Plans for upcoming Year: October 1, 2015 to September 2016
<table>
<thead>
<tr>
<th>State Priority Needs</th>
<th>Objectives</th>
<th>Strategies</th>
<th>National Outcome Measures</th>
<th>National Performance Measures</th>
<th>ESMs</th>
<th>SPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Access and Awareness to Adequate Prenatal Care.</td>
<td>Increase by at least 10% the number of pregnant women coming in for prenatal care from 1st trimester.</td>
<td>Create incentives for pregnant women who comes in 1st trimester and completed 80% of follow up visits. Conduct a group of parental care that falls in the same months. Conduct educational group session during prenatal care and offer incentives for maximum participation. Increase community awareness on the effects of smoking during pregnancy. Strengthen partnerships with stakeholders on activities for pregnant women. Promote the use of the “Smoking cessation during pregnancy: A clinicians guide”</td>
<td>Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (&lt;2,500 grams) Percent of very low birth weight deliveries (&lt;1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (&lt;37 weeks) Percent of early preterm births (&lt;34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks)</td>
<td>Percent of women with a past year preventive medical visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
to helping woman quit smoking” tool among health care provider, from the American College of Obstetricians and Gynecologists. Promote self and provider referral to the Tobacco Program QUIT line (1-684-633-7475). Promote use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) among health care providers.

Perinatal mortality rate per 1,000 live births plus fetal deaths
Infant mortality rate per 1,000 live births
Neonatal mortality rate per 1,000 live births
Post neonatal mortality rate per 1,000 live births
Preterm-related mortality rate per 100,000 live births

**Women/Maternal Health**

**Women/Maternal Health - Plan for the Application Year**

**Plan for Upcoming Year**

1) Looking at implementing a Health Information Center for Maternal and Women.

2) To hire a midwife and a non-Samoan prenatal service provider that is skilled, knowledgeable, great work ethics and has compassion to serve maternal and women.

3) Expand MIECHV Program to serve more women by increasing the # of women enrolled in the program another 5%.

4) Looking at the possibility to conduct women and maternal visits in groups.

5) Provide transportation – either bus or van to transport women without transportation.
6) Contraception to be accessible in the pre-natal clinics.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Reporting Year

NPM#18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Last year's Accomplishments:

Maternal, Infant and Early Childhood Home Visiting program was implemented which has enrolled 96 pregnant women to receive support services from a family support worker. In the past year, there has been an increased in the number of women going in on their first trimester of pregnancy. Through the home visiting program for pregnant mothers who are at high risk, the family support workers offer education and awareness utilizing an evidenced based model known as Healthy Families America. MCH staff have also gained more trainings in the area of maternal and women health through HFA trainings that they are utilizing in the home visits and also one on one counseling or health education with pregnant women at the clinics or in the community. Informercials to promote maternal health were completed in Samoan and English. MCH staff has continued to support various program waves that promote maternal and women health to the public such as Nutrition: Biting into a Healthy Lifestyle, Cervical Screening for women, Stop Smoking and Smoking Kills, Dental Health and Diabetes screening. Through the waves, the MCH program now has been more publicized now than ever before in the past 5 years. MCH was able to conduct the PRAMS survey and the Prenatal Service Survey to capture the challenges to healthcare services for maternal and women. MCH was able to gain an Epidemiologist. MCH assisted with a Prenatal Care Study that was completed in November 2014. Established partnership with the Family Planning Director and staff and works closely in identifying if women enrolled in MIECHV program have received a family planning visit or not and if not, then MCH and Family Planning will work in ways to encourage women for a family planning visit.

Current Activities:

The website and facebook pages for MCH are currently being updated and various public service ads are played throughout the week to promote MCH program and services for maternal and women. Infomercials to promote home visiting program for pregnant women are continuously being aired on radio, tv and also via facebook. The FB page has updates every week to promote maternal and women health. The MCH leaders are working on an incentive program for women/maternal in order to help boost the number of women coming in for a preventive visit and to get
adequate and A+ prenatal care. MCH Division Head and Title V Coordinator were able to attend the AMCHP 2015 Conference and also conducting technical assistance training from MCHB for leadership. Epidemiologist conducted trainings for MCH data team and surveyors to collect data. MCH now looking at utilizing the evidence based model to expand the services to all pregnant women voluntarily. MCH together with Environmental Health Services Program implemented wellness for all MCH staff to promote health in the program as an example to the community. Working on MOU/MOA between the Family Planning program and the Department of Health so contraceptives are accessible to women.
<table>
<thead>
<tr>
<th>State Priority Needs</th>
<th>Objectives</th>
<th>Strategies</th>
<th>National Outcome Measures</th>
<th>National Performance Measures</th>
<th>ESMs</th>
<th>SPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce infant mortality rate.</td>
<td>Increase by 5% of women enrolled in prenatal care services sitting in a nutrition and pregnant woman lifestyle session.</td>
<td>Provide incentives for women who have attended nutrition and pregnant women lifestyle session conducted by Title V staff. Collaborate with Tobacco Program, Prental Clinics and OBGYN clinics to ensure Clinicians are screening every client for smokers and refer for treatment and / or counselling in order to quit.</td>
<td>Perinatal mortality rate per 1,000 live births plus fetal deaths</td>
<td>Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)</td>
<td></td>
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<tr>
<td>Increase breastfeeding babies at 3 months and 6 months of age.</td>
<td>Increase breastfeeding in 3 and 6 month old infants by 10%</td>
<td>Establish / Update a baseline data for this population by the end of FY2016. Continue to increase awareness and promotion in the community,</td>
<td>Perinatal mortality rate per 1,000 live births plus fetal deaths</td>
<td>Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)</td>
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</tbody>
</table>
Perinatal/Infant Health
Perinatal/Infant Health - Plan for the Application Year

Plan for Upcoming Year

1) Finalize the plan for the NBS and implement it this new fiscal year.

2) More outreaches into the community for immunization, breastfeeding, smoke free environment,

3) Banners an poster boars to be placed the prenatal clinic and well baby clinics to encourage breastfeeding.

4) Website and Facebook page to promote importance of breastfeeding, being fully vaccinated, healthy choices of food, promote a smoke free environment, and much more.

5) MCH to enforce the Smoke Free Environment Act.

6) Need tobacco cessation methods to help pregnant women quit smoking.
7) Incentives for women to take advantage of prenatal care.

**Perinatal/Infant Health - Annual Report**

**NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>50</td>
<td>49</td>
<td>48</td>
<td>47</td>
<td>46</td>
</tr>
</tbody>
</table>

**NPM#01:** Percent screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screenings.

**Last year’s Accomplishments:**

Though the NBS has not been implemented and there is NO data for this NPM, the NBS was brought up as a project that needs to be implemented as a CoIIN project for American Samoa. Plans with Deputy Director of Health, one of LBJ’s pediatrician, a private medical physician and MCH leaders were present at the CoIIN meeting and this topic was discussed. Discussion continued on last year.

**Current Activities:**

Had few conversations with all involved or should have a part in the NBS and still awaiting the meeting to finalize plan and move forward.

**NPM#07:** Percent of 19 to 35 months old who have received full scheduled age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

**Last year’s Accomplishments:**

Though the number identified showed only the data that was input into the WEBIZ which showed a drastic drop in the % of children receiving fully scheduled immunization, after the WEBIZ got updated, the % was more than what was reported in 2013. There has been an increase in the % last year in which added staff at the Well Baby Clinic conducted follow up calls and reminders for children’s appointment for their vaccinations. MCH supported Immunization outreaches to the public and have also utilized its staff as manpower to conduct health fairs to promote vaccinations for children.

**Current Activities:**
MCH support staff are still stationed at the Well Baby Clinics to conduct follow up calls and appointment reminders. MCH looking into incentives to promote and reward parents who are bringing in their children to get fully immunized. MCH continue to advocate for mothers who breastfed their children. Established website for MCH which will include and promote breastfeeding.

- 

**NPM#11:** The percent of mothers who breastfeed their infants at 6 months of age.

**Last year’s Accomplishments:**

More women attempted and tried breastfeeding before they were discharged from the hospital. The Breast Feeding Initiative has constantly been promoted in the LBJ Tropical Medical Center and its Lactation room was also promoted for working mothers and all mothers to take advantage of a place they can breastfeed child or express their milk. According to WIC, there has been an increase in the number of women breast-feeding at 6 months of age. WIC and MCH continued their collaboration in the Breastfeeding Week of August 2014. MCH showed strong support at a WAVE that was conducted with partnership from the WIC office. Also through the MIECHV program, the family support workers are encouraging mothers to breast feed child by informing them and reminding them of benefits even before they give birth. Two TV talk shows in the Samoan language and 2 radio talk shows were conducted prior to breastfeeding week to encourage breastfeeding mothers. WIC conducted Breastfeeding training for MCH Title V and MIECHV staff. Hospital and WIC office now have banners and posters that are promoting Breastfeeding only as the best feeding for child. NO posters of any other feeding on hospital walls and prenatal clinics.

**Current Activities:**

MCH created its Workplace Baby Friendly Initiative for its employees for working mothers who are exclusively breastfeeding their child. MCH working on a Breastfeeding incentive for mothers who BF their child exclusively until 6 months of age. Brochures for Breastfeeding in the Samoan language have been created. MCH are currently recruiting from WIC for mothers to enroll into the home visiting program so that Breastfeeding can also be encouraged up to 6 months of age. A nutrition fair was conducted that also promoted breastfeeding.

**NPM#15:** Percentage of women who smoke in the last three months of pregnancy.

**Last year’s Accomplishments:**

The MIECHV program was implemented and pregnant women enrolled in the home visiting program have shown and increase in the % of women who stopped smoking as soon as they found out they were pregnant. Through the HV program, family support workers are able to educate pregnant women during pregnancy and encourage them after pregnancy in regards to smoking and how it can affect the pregnancy and the child.

Designated smoking areas for workplaces and public places were enforced by the Environmental Health Services Program, Department of Human and Social Services, Maternal and Child Health and the Department of Health.
Current Activities:
MCH continues to utilize the Home visiting program to educate pregnant mothers in regards to smoking and the consequences. Also looking into incentives for women who stays smoke free from pregnancy to the 1\textsuperscript{st} 3 years of their child's life.

**NPM#17:** Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Last year's Accomplishments:
There is an MCH Rep in the LBJ Rounds for issues and concerns relating to maternal, perinatal and infant mortality.

Current Activities:
MCH staff (providers and health educators) continue to work to promote prenatal care and to prevent low birth weight infants. Prenatal benefit health education sessions are conducted as a group at the Prenatal clinics in Tafuna Health Center. Individual sessions are conducted at the Amouli and Leone Clinics and also at the Maternity Ward and OB-GYN Clinic.
<table>
<thead>
<tr>
<th>State Priority Needs</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Childhood Obesity.</td>
<td>Increase by 10% # of children participating in physical activity in all schools.</td>
</tr>
<tr>
<td></td>
<td>Increase by 10% # of school teachers actually conducting physical activity with class during physical education classes.</td>
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<td></td>
<td>Increase by 10% # of schools with most PE classes that has the most turnout in #s of individuals actually participating during PE classes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies</th>
<th>National Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct physical activity sessions in schools (elementary) to promote the benefits. Incentive for the schools who has the most physically active children.</td>
<td>Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Performance Measures</th>
<th>ESMs</th>
<th>SPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>State Priority Needs</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote evidence based developmental screenings for children 0-5 years of age.</td>
<td>Implement developmental screenings. Train workforce in conducting developmental screenings.</td>
</tr>
</tbody>
</table>

| Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health | Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool |

Page 66 of 191 pages
Child Health

Child Health - Plan for the Application Year

1) To implement development screenings. Utilize development screenings that the MIECHV program to conduct on the rest of the population.

2) To encourage physical activities in school.

3) To conduct more nutrition classes during School Lunch program more than once a month for each schools.

4) To partner with Department of Youth and Women's Affair for their summer program and after school program for physical activities.

Child Health - Annual Report

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>1</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
</tr>
</tbody>
</table>

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

Past:

1) Implemented nutrition classes in DOE during school lunch time in 4 elementary schools.

2) Conducted Nutrition Fair for the Territory to promote healthy lifestyle for children and women.

3) Implemented wellness for MCH staff to set an example for the community and community are invited to join.

4) Conducted a Nutrition Infomercial that is being played on social media and local tv.

Current:

1) Working on plan for more awareness and promoting healthy lifestyle.
2) Did a Project Change Activity utilizing 2015 Spokesmodel Mr. Raynor Whitcombe and 2015 Mr. American Samoa to conduct motivational speeches to 6 schools in the Territory.

3) Also did the Project Change video to encourage project change message to young people.
<table>
<thead>
<tr>
<th>State Priority Needs</th>
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<th>SPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Immunization Coverage Rates.</td>
<td>Increase immunization coverage rates among adolescents</td>
<td>Collaborate with ASIP and key partners including families and the community to ensure that children get fully immunized prior to entering schools. Promote and disseminate evidence-based information on immunizations for adolescent population. Increase program implementation that uses innovative approaches to increase awareness so families can make informed decisions. The MCH staff will also collaborate with the Department of Health's Medical and Dental Staff (MDS), ASCHC Clinical Director, Executive Director and CHC Quality</td>
<td>Adolescent mortality rate ages 10 through 19 per 100,000</td>
<td>Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.</td>
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<td></td>
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<td>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</td>
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<td></td>
<td></td>
<td>Adolescent suicide rate, ages 15 through 19 per 100,000</td>
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<td>Percent of children with a mental/behavioral condition who receive treatment or counseling</td>
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<td></td>
<td>Percent of children in excellent or very good health</td>
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<td></td>
<td>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</td>
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<td></td>
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<td></td>
<td>Percent of children 6 months through 17 years who are vaccinated annually against seasonal</td>
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</table>
**Adolescent Health**

**Adolescent Health - Plan for the Application Year**

1) To conduct awareness in schools from lower lever grades to high schools and conduct them in Samoan and English.

2) To do more contests for theme of "Bullying or Being Bullied" in elementary and high school to prevent these type

<table>
<thead>
<tr>
<th>Prevent adolescents from being bullied or bullying others</th>
<th>Decrease adolescents who are being bullied or bullying others</th>
<th>Group Counselling and focus group sessions.</th>
<th>Adolescent mortality rate, ages 10 through 19 per 100,000</th>
<th>Percent of adolescents, ages 12 through 17, who are bullied or who bully others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement Manager in developing a plan to work with health care providers on making health prevention visits more teen friendly through Primary Health Care Clinics. Also develop a plan to have Well Adolescent Visits mandatory annually. All high school students who play competitive sports are required to get a physical screening prior to playing. This should be mandatory for every adolescent student.</td>
<td>influenza</td>
<td>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</td>
<td>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</td>
<td>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</td>
</tr>
</tbody>
</table>
of behaviors.

3) To hire more providers to conduct wellness visits for adolescents.

Adolescent Health - Annual Report

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>80</td>
<td>60</td>
<td>40</td>
<td>20</td>
<td>10</td>
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</table>

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

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>20</td>
<td>30</td>
<td>50</td>
<td>70</td>
<td>80</td>
</tr>
</tbody>
</table>

Past:

1) Adopted a School (Pago Elementary) and MCH together with the Sanitation program would conduct clean up of school environment throughout the school year.

2) MCH conducted a contest among the classes of Pago Elementary to "Stop Bullying" and out the 8 grade levels, 4 groups joined and did a video. Classes were rewarded with some school supplies and snacks for the children.

3) Children are more opened to MCH staff in regards to Bullying and MCH Staff are working on other activities to keep them focus on helping others instead of bullying others.

Current:

1) MCH staff continue to provide support to Pago Elementary school in clean up and keeping their environment clean and safe especially with the outbreak of dengue fever, Chikungunya and flu.

2) MCH working on plan to implement the same thing for other elementary schools one at a time and then up to the high school levels.

3) Training workforce in the topics of Bullying - understanding the signs and being able to communicate with those being bullied or those bullying others.

4) MCH staff looking to hire a pediatrician specifically for Adolescent health. There is no well visits, and MCH is looking in to conducting simple screenings to start off while awaiting a pediatrician or nurse practitioner that targets
children.
<table>
<thead>
<tr>
<th>State Priority Needs</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Improve system of care for CYSHCN.</td>
<td>Strengthening workforce specifically for CYSHCN.</td>
<td>Conduct TA for health care providers in this specific population.</td>
<td>Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system</td>
<td>Percent of children in excellent or very good health</td>
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<tr>
<td></td>
<td>Increase by 25% the number of children and youth with special health care needs accessing an ongoing, coordinated, and comprehensive care within a medical home.</td>
<td>Conduct field days for this population at least twice a year for this type of population.</td>
<td></td>
<td>Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Continuous collaborative efforts with all key partners including family advocates and medical providers are ongoing to assist CYSHCN to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families. These services are family-centered, community-based and culturally competent.</td>
<td></td>
<td>Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza</td>
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<td></td>
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<td></td>
<td>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</td>
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</table>
Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

1) MCH plans to implement an activity day specifically for this population in groups that has similar challenges.

2) Hire a Provider specifically for CYSHCN. One that has a heart and compassion to serve this population and can conduct well visits for them.

3) Looking at the possibility of a mobile van for services to cater to this type of population.

Children with Special Health Care Needs - Annual Report

NPM 11 - Percent of children with and without special health care needs having a medical home

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
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</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>30</td>
<td>31</td>
<td>32</td>
<td>33</td>
<td>34</td>
</tr>
</tbody>
</table>

Past:

MCH staff has done a tremendous job in increasing the # of CYSHCN they serve in the past year. The number has increased 8 times.

The CSHCN team was created which consists of a case worker, field worker and the nurse practitioner that serves this type of population.

The # of Families that are satisfied with the service have also increased.

The team created new banners, pamphlets and brochures.

Established partnership with SPED again and now working closely with SPED in regards to clients that are being
linked to the CYSHCN program under Title V.

Caseworker: Taua Tauanu'u R-Z Files
U.Y: Received new wheelchair & bed. Taua connected with SPED and right away they helped participant.

U.I.: Participant requested ramp for wheelchair for 1 year. Voc-Rehab started on the ramp for wheelchair from house to where bus arrives for pick up for school. They have been waiting for 2 years.
Taufa connected with Johnathan Fanene for help.

T.F.: Started school 1 month ago, and he has been waiting for a year to be enrolled.

Caseworker: Temukisa Aneterosa A-H Files
F.F. : Family was applying for WIC since infant and now is receiving WIC and have received car seat from CSHN.
Temukisa connected with participant and WIC and DPS for car seat and waiting process was 3 years.

A.J.: Participant received SNAP after trying for 6 years.

A.A.: Participant is finally in school.

Caseworker: Tammy Laga I-Q Files
I.J.: Participant started home school. Tammy connected with SPED and worked with teacher.

O.O.: Participant started home school. Tammy connect with SPED and teacher.

M.A.: Participant started school and he is 7 years old.
Tammy connected with SPED, after SPED miscommunication with Pava’i’a’i school for years.

Current:
The CSHCN team is now changed to include youths - CYSHCN. The team continues to gain more clients and conduct follow up visits. Shriners were on island from April 20 - 24, 2015 and CYSHCN were able to transport some of their clients for appointments.
The CYSHCN Team was able to transitioned over 2 high school students to adulthood by preparing youth for graduation from high school and assisting them to identify their goals and plans for the future.
The CYSHCN continues to link clients to available resources on island and also at the same time receiving referrals from Part C and MIECHV program.
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Promote oral health in all 6 domains.</td>
<td>By 2020, decrease the rate of Rheumatic Heart Disease through secondary prophylaxis by at least 5%.</td>
<td>Establish baseline data for all Objectives by July 2016. Increase oral health awareness for all MCH population during Dental Month Activities, PTA and guardians focus groups, classroom oral health talks, dental PSAs disseminated to all partners to be viewed by their clients in their waiting areas, TV talks and other media avenues.</td>
<td>Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health</td>
<td>A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year</td>
<td></td>
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</tr>
</tbody>
</table>
and schools.

Increase children ages 9 to 35 months getting a fluoride varnish at least twice a year.

Ensure that there are opportunities for CME for all medical providers focusing on improving oral health in order to improve and increase their service capacity.

Improve data collecting and reporting for all dental providers serving children 1-17 years of age.

Ensure that all CYSHCN identify and address their dental needs within their medical homes.

Ensure that all pregnant women identify their dental homes, get referred and receive a dental screening and cleaning prior to giving birth.

| Reduce Acute Rheumatic | By 2020, decrease the | Increase awareness in all |
| Fever and Rheumatic Heart Disease. | rate of Rheumatic Heart Disease through secondary prophylaxis by at least 5%. By 2020, increase awareness and screening methods for children ages 4-17 on Acute Rheumatic Fever and Rheumatic Heart Disease. | sectors of the community
Provide continuing education and training for health care professionals on RHD
Increase accessibility of health care services to address needs of RHD population (Maternal and Children)
Increase compliance in secondary prophylaxis
Increase # of children and women screened for RHD
Build partnerships with local (LBJ Hospital, Private medical providers), National (American Heart Association, CDC, MCHB) and International (World Heart Federation, World Health Organization) associates. |
Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

1) wanting to purchase a mobile dental clinic for children in the community as a lot of them do not have the money nor transportation to bring their children in for dental visits.

2) Purchase dental equipment such as portable dental chairs and all necessary resources in order to conduct outreaches in the communities and villages.

3) Continue to promote dental health in children and women and especially pregnant women.

Cross-Cutting/Life Course - Annual Report

NPM-13 A) Percent of women who had a dental visit during pregnancy

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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</thead>
<tbody>
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<td>6.0</td>
<td>8.0</td>
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</tbody>
</table>

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

<table>
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<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
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<td>10.0</td>
<td>15.0</td>
<td>20.0</td>
<td>25.0</td>
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</tbody>
</table>

Past
The school dental team continues to provide dental varnishing for 3rd graders in most of the schools.
<table>
<thead>
<tr>
<th>LOCATION/VENUES</th>
<th>ACTIVITY</th>
<th>NUMBER OF CLIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHOOLS</td>
<td>SCHOOL-BASED DENTAL CLINIC</td>
<td>1148</td>
</tr>
<tr>
<td>WELL BABY CLINICS</td>
<td>SCREENING &amp; FLUORIDE TREATMENT</td>
<td>826</td>
</tr>
<tr>
<td>WIC</td>
<td>SCREENING &amp; FLUORIDE TREATMENT</td>
<td>327</td>
</tr>
<tr>
<td>HOMEVISITS</td>
<td>SCREENING &amp; FLUORIDE TREATMENT &amp; REFERRALS OF CSN CLIENTS</td>
<td>11</td>
</tr>
<tr>
<td>HEALTH FAIRS</td>
<td>ORAL HEALTH PROMOTION</td>
<td>344</td>
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<tr>
<td>MARKET</td>
<td>ORAL HEALTH PROMOTION</td>
<td>323</td>
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<tr>
<td>DENTAL MONTH</td>
<td>ORAL HEALTH PROMOTION</td>
<td>1263</td>
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<tr>
<td>CAREER DAY</td>
<td>ORAL HEALTH PROMOTION</td>
<td>97</td>
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<tr>
<td></td>
<td><strong>TOTAL CLIENTS SERVED IN 2014</strong></td>
<td><strong>4339</strong></td>
</tr>
</tbody>
</table>

*Third Grade Fissure Sealant Coverage: 66.7% screened and 60.4% Sealed.*

The MCH Dental Team achieved an annual indicator of **60.4** for the MCH National Performance Measure #9. With hard work and determination, the dental team was able to report an increase in the number of third grade students with fissure sealant (numerator) from year 2013 (58.9%) to year 2014. The denominator used is the total 2013-2014 DOE enrollment of **1075 third grade students**.
Table I: 2013-2014 School Year Fissure Sealant Coverage

<table>
<thead>
<tr>
<th>SCHOOLS</th>
<th>3RD GRD SCREENED</th>
<th>3RD GRD SEALED</th>
<th>% Sealed</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALATAUA</td>
<td>27</td>
<td>27</td>
<td>100</td>
</tr>
<tr>
<td>AUA</td>
<td>58</td>
<td>55</td>
<td>94.8</td>
</tr>
<tr>
<td>FALEASAO</td>
<td>8</td>
<td>7</td>
<td>87.5</td>
</tr>
<tr>
<td>FITIUTA</td>
<td>5</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>Iakina*</td>
<td>11</td>
<td>11</td>
<td>100</td>
</tr>
<tr>
<td>KANANA FOU*</td>
<td>39</td>
<td>36</td>
<td>92.0</td>
</tr>
<tr>
<td>LUPELELE</td>
<td>68</td>
<td>64</td>
<td>94.0</td>
</tr>
<tr>
<td>MANULELE</td>
<td>85</td>
<td>78</td>
<td>91.7</td>
</tr>
<tr>
<td>MATAFAO</td>
<td>51</td>
<td>47</td>
<td>91.2</td>
</tr>
<tr>
<td>MIDKIFF</td>
<td>61</td>
<td>56</td>
<td>91.8</td>
</tr>
<tr>
<td>OLOSEGA</td>
<td>6</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>COLEMAN</td>
<td>71</td>
<td>63</td>
<td>88.7</td>
</tr>
<tr>
<td>PAVAIAI</td>
<td>105</td>
<td>69</td>
<td>65.7</td>
</tr>
<tr>
<td>PETELI ACADEMY*</td>
<td>6</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>SAMOA BAPTIST*</td>
<td>19</td>
<td>18</td>
<td>94.7</td>
</tr>
<tr>
<td>SILIAGA</td>
<td>22</td>
<td>22</td>
<td>100</td>
</tr>
<tr>
<td>ST. THERESA*</td>
<td>11</td>
<td>11</td>
<td>100</td>
</tr>
<tr>
<td>TAFUNA</td>
<td>64</td>
<td>64</td>
<td>100</td>
</tr>
<tr>
<td>TFCHC FREE CLINIC</td>
<td>5</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>717</strong></td>
<td><strong>645</strong></td>
<td><strong>90%</strong></td>
</tr>
</tbody>
</table>

The target level for receiving fissure sealant continues to be third grade students, territorial-wide. As shown in Table I, a total number of 717 third grade students were screened in the school year 2013-2014. This is **66.7% of the total DOE enrollment** of 1075 third grade students recorded in May 2014. Ninety percent (90%) of all third grade screened had at least one permanent molar sealed. By using the DOE enrollment number as the denominator, **60.4%** was obtained as the annual indicator for this performance measure.
Third Grade Students Served:

All those who were screened received a cleaning, topical fluoride (varnish) treatment, oral hygiene instructions and a report card to take home. Screening usually occurs on the first day of school visit.

The MCH team’s main target were third grade students and Children with Special Health Care Needs (CSHCN).

Shown in Table II are the numbers of students who were unable to receive fissure sealant and the reasons why. Some of these reasons were:

1. All first permanent molars are carious (all cavities).
2. Molars are missing because they were extracted previously due to dental caries.
3. Students were absent when called for fissure sealant.
4. Students have bad gagging reflex (BGR) and were unable to receive treatment.
5. A whole class of third grade students in Pavaiai Elementary School were on a fieldtrip when it was their turn to receive treatment.

Last year the team was fortunate to travel to the Manua Islands. All three schools (Olosega, Fitiuta and Faleasao) were served.

<table>
<thead>
<tr>
<th>CLINIC</th>
<th>NUMBER OF CHILDREN SERVED IN THE CLINICS/HOME GROUPED BY AGE.</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 YR</td>
<td>2 YRS</td>
</tr>
<tr>
<td>AMOULI</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>HOMEVISIT</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>LEONE WBC</td>
<td>45</td>
<td>24</td>
</tr>
<tr>
<td>TAFUNA WBC</td>
<td>242</td>
<td>83</td>
</tr>
<tr>
<td>WIC</td>
<td>54</td>
<td>63</td>
</tr>
<tr>
<td>Grand Total</td>
<td>351</td>
<td>173</td>
</tr>
</tbody>
</table>

A total number of 351 one year old toddlers were screened and received Fluoride Varnish in 2014. More children would have been treated if this was a whole year round service. Unfortunately, the data obtained for this State Measure is from the MCH Dental Team’s summer program as well as the free clinic held at the Tafuna CHC during the Children’s Dental Health Month.
Nurses were trained but due to staff shortage, are unable to provide this service themselves.

Current:

The Dental Team is currently stationed again at the Well Baby Clinics as well as WIC for the summer. So far, data obtained for year 2015 alone has doubled that of year 2014. This is due to hardwork, team effort and increase in the number of staff. Central WBC or CII is also served twice a week.

Working on plan to promote dental visits for pregnant women. Currently discussing leverage of services with dental clinic so pregnant women are served the same day she is scheduled for her prenatal visit in order to save time and money.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

The Department of Health continues to build its workforce and its leaders as there is always a continuous change of staff when there is a transition of a new every 4 years. There is a constant shift of staff from one location to another in order to clearly defined job roles. Once all understand their job roles, responsibilities are designated in a way that builds capacity to provide more and improved services through the Title V Program and the MIECHV program. Currently, the workforce that is currently funded by Title V is relatively new to MCH. This is the period to promote the development of the workforce.

In order to increase the capacity of the workforce, the MCH leadership has determined the following areas of focus for workforce development efforts. Leadership and systems thinking, management skills, workforce development and continuous training of workforce competency. The MCH workforce reported low competency in the ability of the Department of Health’s Finance team to manage grants.

In order to address theses and build capacity among the Title V Workforce, online training courses are continually offered via webinars. The Title V workforce will be encouraged to participate in all pertinent trainings from specialists coming from off island and/or local specialists in the areas relating to Maternal and Child Health. Workforce will continue to sit in trainings on topics such as grants, and budgets and public health sciences will be encouraged among all Title V staff. The Title V manager and Title V Coordinator will be conducting education on block grant activities and equipping the workforce to develop family/consumer partnerships in all programs. Additionally, funds are in place for the workforce to attend conferences and trainings as needed. MCH leaders have looked into taking the Senior Leaders Course and utilize the mchnavigator.org to self teach themselves.

Another focus of developing the workforce will be on implementing strategies specific to adolescent health. Title V
currently has no workforce specifically dedicated to adolescent health programs, however MCH will be expanding in the upcoming reporting cycle to reach this population. There is no designated adolescent health program or staff within MCH. In order to address this population, MCH will partner with Aiga Manuia Home Visiting Program to assist with bullying prevention programs.

II.F.3. Family Consumer Partnership

MCH recognizes the value that family and consumer partnerships add to developing strategies that meet the needs of the populations they are intended to address. While there are several existing family/consumer partnerships engaged in planning activities, MCH will work to expand these partnerships in both number and substance. In order to develop a plan for engaging family/consumer partnerships, MCH staff developed a strategic plan to engage families. Staff from all programs, including but not limited to CYSHCN programs, participated in the development of the plan.

Staff developed the following goals, objectives and value statements to serve as the overarching framework for the strategic plan and activities moving forward:

Goal: To increase family participation in all MCH programs

Objectives:
- Increase families’ awareness of MCH and its programs
- Increase families’ knowledge and capacity by providing MCH and Title V training
- Increase families’ access to MCH programs and services
- Increase opportunities for families to participate in the work of MCH

Value Statements:
- We value our families
- We want families at the table (shared decision-making)
- We want MCH programs to be the best they can be
- Families are our target service recipients
- Families know best what they need
- Families have the ability to better assess programs and services
- Families are the key to improving health outcomes

MCH developed the following activities to be accomplished during the five-year reporting cycle to increase family and consumer partnerships:

Activity 1. Leverage partnerships with local state agencies/non governmental organizations/grant contractors to increase family participation. This activity will be conducted by the MCH Division Head in coordination with state agencies/non governmental organizations and will be the primary method by which families are recruited to build partnerships.

Activity 2. Use the MCH website to share information and resources. The MCH Division Head and Quality Assurance Manager will conduct this activity. The MCH website will be redone to be user-friendly and provide information about MCH services and opportunities for families to be involved.

Activity 3. Use the family engagement specialist to touch families and provide education. The MCH Family Engagement Specialist will begin to work directly with families in the upcoming years and provide education to them on MCH issues. Trainings will start with Family Leadership Training, Public Health 101 and MCH 101. More trainings
will then be added to include Title V and other MCH program specific trainings as well as cultural competency. Trainings currently planned are:

- Family Support Worker for pregnant women.
- Early Intervention Services: Speech Therapy, Occupational Therapy, Physical Therapy, Vision Services, Nursing Services, Special Instruction, Family Training & Counseling, etc.

Parent and Professional Training/Webinars

- Developmental Milestones
- Medical/Dental Home
- Cultural Competency
- What is a Child’s “Natural Environment”? 
- What is “Child Find”?
- Educational Rights and Needs for the Homeless Population
- Emotional/mental health issues related to families
- Inclusion of children with special needs/disabilities in Early Head start, Head start and child care settings

Activity 4. Develop a communications plan. The MCH Division Head and Title Coordinator are responsible for developing a communication plan for families. The communications plan will include marketing strategies and development of consistent messaging around MCH’s values regarding family partnerships.

Activity 5. Make efficient use of MCH funding/redirect contract funds. All MCH Program contract owners will be responsible for efficiently using their funding to engage families and consumers. The administrative staff will work with utilizing some fund to implement New Born Screening.

Activity 6. Trainings. The MCH Director of Quality will train MCH staff on building family/consumer partnerships and ensure compliance with the developed values and objectives.

Objective 7. Advisory Groups. Program Director will work with the MCH Division Head and Title V Coordinator to build advisory groups to address each priority need. Each advisory group will have family representation. The purpose of the advisory groups is to bring the needs of families to the forefront of program planning and advise on program strategies.

Objective 8. Gap Analysis. The MCH Division Head and DOH EPI will perform a Gap Analysis to compare actual performance with desired performance regarding planned activities for increasing family/consumer partnerships.

Objective 9. Program experience/evaluations. The MCH Division Head will perform program experience evaluations to assess how satisfied both families and program staff are with the family/consumer partnerships that were established.

II.F.4. Health Reform

II.F.4. Health Reform

The Title V MCH Block Grant Program is providing gap-filling health care services to MCH populations that do not have coverage for health care services, particularly for children and youth with special health care needs. For families that do not qualify for American Samoa’s Medicaid and SCHIP programs, they are still responsible to pay out of their own pocket.

In July 2014, the Obama administration finally found a solution to the territories issue. The administration decided to simply exempt insurers operating in the territories from the coverage requirements in the ACA. The Health and Human Services department wrote that the definition of “state” does not include the self-governing territories. As a
result, insurers in the territories can still refuse coverage to certain applicants and do not have the rate-change regulations that the states have, among other exemptions.

As the ACA implementation continues, issues arise that could not have been easily foreseen in the drafting of the bill. The government agencies overseeing the rollout of the ACA have realized that the unique situation of self-governing U.S. territories requires a different approach to the health insurance marketplace there.

II.F.5. Emerging Issues

There are several emerging issues that could impact the health status of women and children in American Samoa that were not addressed by the state action plan. New Born Screening is a topic gaining attention in American Samoa. This was considered a priority need, but was not selected due to low capacity within the agency to address the topic. Also, strategies for addressing NBSs are just emerging. Due to the large impact that NBSs can have on a child’s health and wellbeing later in life, it is important to monitor data regarding a child’s developments and considers potential opportunities to partner with organizations.

Another emerging area impacting the health of adolescents in the Territory is strep throat could lease to Rheumatic Heart Disease. The topic emerged during focus groups conducted for the needs assessment.

More will be identified in the 2nd reporting year.

II.F.6. Public Input

Public input was obtained using a variety of methods throughout the needs assessment process and in the development of the Annual Report/Application. Sections of the needs assessment were passed out during needs assessment meetings for comments. Announcements were sent to partners, stakeholders and community members. In order to solicit as much awareness as possible about the public comment, presentations were made to stakeholders during meetings. The MCH Division Head presented an overview of Title V and the importance of the public comment process. Inputs and feedbacks were requested from stakeholders and community partners.

II.F.7. Technical Assistance

Further Technical Assistance is requested for MCH leadership. Also, need more TA in the areas of CYSHCN in improving systems of care when resources are limited. Need TA for Provider dealing with CYSHCN and what a medical home is.
### III. Budget Narrative

<table>
<thead>
<tr>
<th></th>
<th>2012 Budgeted</th>
<th>2012 Expended</th>
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<td>Other Funds</td>
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<thead>
<tr>
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<tr>
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<td>$ 482,901</td>
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<td>$</td>
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<td>Unobligated Balance</td>
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<td>$</td>
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<tr>
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<tr>
<td>Other Funds</td>
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<td>Program Funds</td>
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<td>$ 908,325</td>
<td>$ 2,091,045</td>
<td>$</td>
</tr>
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Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.
<table>
<thead>
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<tr>
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<tr>
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</tr>
<tr>
<td>Other Funds</td>
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</tr>
<tr>
<td>Program Funds</td>
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</tr>
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<td>Other Federal Funds</td>
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<td>Total</td>
<td>$2,188,213</td>
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</tbody>
</table>

**III.A. Expenditures**

Difference in amount budgeted compared to amounts expended is based on amount that is dispersed to Grantee.

**III.B. Budget**

Maintenance of Effort is maintained through the State in kind match using local investments such as staffing in both administration and direct health services.

Staffing is supporting MCH services include the health center staff, nurses, clerks, providers, administrative staff, health educators, health assistants.

The Director of Nursing serves as the Project Director for the Title V Grant. She oversees all MCH Grants and Programs.

The Title V Coordinator manages program staff as well as oversee the CSHCN program.

The Finance Manager is paid locally and provides assistance to MCH's financial operation.

Local infrastructure for the MCH program is very vital for the operation. There is still great need for more providers needed for the MCH operation.

There is a tremendous need for Training of current MCH Staff as well as all MCH medical providers and clinicians on new MCH framework and Domains by promoting continuous education and online training (MCH Leadership Competencies and National Center for Education in MCH, 5-Minute in the MCH Navigator) to increase workforce development and service capacity for all MCH population.

Please refer to supporting documents attached for the breakdown of ASMCH TITLE Budget.
IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid MOU.pdf
V. Supporting Documents

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

Supporting Document #01 - Signed Copy_Letter from the MCH Title V Director (1).pdf

Supporting Document #02 - Budget Narrative for Title V Block Grant Application FY 2016 Bud Narrative.pdf

Supporting Document #03 - Budget Narrative for Title V Block Grant Application FY 2016 SF 424 A-2.pdf

Supporting Document #04 - Budget Narrative for Title V Block Grant Application FY 2016 Personnel Staffing.pdf
VI. Appendix

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## 1. FEDERAL ALLOCATION

(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)

<table>
<thead>
<tr>
<th>Description</th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Preventive and Primary Care for Children</td>
<td>$200,000</td>
<td>$155,015</td>
</tr>
<tr>
<td></td>
<td>(33.3%)</td>
<td>(32.1%)</td>
</tr>
<tr>
<td>B. Children with Special Health Care Needs</td>
<td>$200,000</td>
<td>$155,015</td>
</tr>
<tr>
<td></td>
<td>(33.3%)</td>
<td>(32.1%)</td>
</tr>
<tr>
<td>C. Title V Administrative Costs</td>
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<td></td>
<td>(10%)</td>
<td>(10%)</td>
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## 2. UNOBLIGATED BALANCE

(Item 18b of SF-424)

<table>
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<th>Description</th>
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## 3. STATE MCH FUNDS

(Item 18c of SF-424)

<table>
<thead>
<tr>
<th>Description</th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
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<tr>
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<td>$425,424</td>
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## 4. LOCAL MCH FUNDS

(Item 18d of SF-424)

<table>
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<tr>
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<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
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<tr>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

## 5. OTHER FUNDS

(Item 18e of SF-424)

<table>
<thead>
<tr>
<th>Description</th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

## 6. PROGRAM INCOME

(Item 18f of SF-424)

<table>
<thead>
<tr>
<th>Description</th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

## 7. TOTAL STATE MATCH

(Lines 3 through 6)

<table>
<thead>
<tr>
<th>Description</th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Your State’s FY 1989 Maintenance of Effort Amount</td>
<td>$318,604</td>
<td></td>
</tr>
</tbody>
</table>

## 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL

(Same as item 18g of SF-424)

<table>
<thead>
<tr>
<th>Description</th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,134,000</td>
<td>$908,325</td>
</tr>
</tbody>
</table>

## 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.

<table>
<thead>
<tr>
<th>Description</th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. OTHER FEDERAL FUNDS</td>
<td>$1,054,213</td>
<td></td>
</tr>
<tr>
<td>(Subtotal of all funds under item 9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</td>
<td>$2,188,213</td>
<td>$908,325</td>
</tr>
<tr>
<td>(Partnership Subtotal + Other Federal MCH Funds Subtotal)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### FY14 Annual Report Budgeted

1. **FEDERAL ALLOCATION**
   - A. Preventive and Primary Care for Children: $155,015
   - B. Children with Special Health Care Needs: $155,015
   - C. Title V Administrative Costs: $51,600

2. **UNOBLIGATED BALANCE**: $0

3. **STATE MCH FUNDS**: $425,424

4. **LOCAL MCH FUNDS**: $0

5. **OTHER FUNDS**: $0

6. **PROGRAM INCOME**: $0

7. **TOTAL STATE MATCH**: $425,424

---

### FY16 Application Budgeted

9. **OTHER FEDERAL FUNDS**

   - Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program: $1,000,000
   - Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI): $54,213
### Field Level Notes for Form 2:

1. **Field Name:** 1.FEDERAL ALLOCATION  
   **Fiscal Year:** 2014  
   **Column Name:** Annual Report Expended  
   **Field Note:** NOA for y2014 received with this total.

2. **Field Name:** Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program  
   **Fiscal Year:** 2016  
   **Column Name:** Application Budgeted  
   **Field Note:** FY2015 for $1000,000 already issued and is utilized to conduct MIECHV home visiting for pregnant women and teens.

3. **Field Name:** Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)  
   **Fiscal Year:** 2016  
   **Column Name:** Application Budgeted  
   **Field Note:** FY15 issued partial so far of $54,213.

**Data Alerts:** None
Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: American Samoa

<table>
<thead>
<tr>
<th></th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. TYPES OF INDIVIDUALS SERVED</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IA. Federal MCH Block Grant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Pregnant Women</td>
<td>$ 70,000</td>
<td>$ 30,000</td>
</tr>
<tr>
<td>2. Infants &lt; 1 year</td>
<td>$ 70,000</td>
<td>$ 30,000</td>
</tr>
<tr>
<td>3. Children 1-22 years</td>
<td>$ 200,000</td>
<td>$ 155,015</td>
</tr>
<tr>
<td>4. CSHCN</td>
<td>$ 200,000</td>
<td>$ 155,015</td>
</tr>
<tr>
<td>5. All Others</td>
<td>$ 0</td>
<td>$ 0</td>
</tr>
<tr>
<td><strong>Federal Total of Individuals Served</strong></td>
<td>$ 540,000</td>
<td>$ 370,030</td>
</tr>
<tr>
<td><strong>IB. Non Federal MCH Block Grant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Pregnant Women</td>
<td>$ 15,000</td>
<td>$ 1,067</td>
</tr>
<tr>
<td>2. Infants &lt; 1 year</td>
<td>$ 15,000</td>
<td>$ 1,072</td>
</tr>
<tr>
<td>3. Children 1-22 years</td>
<td>$ 289,740</td>
<td>$ 12,212</td>
</tr>
<tr>
<td>4. CSHCN</td>
<td>$ 163,161</td>
<td>$ 331</td>
</tr>
<tr>
<td>5. All Others</td>
<td>$ 0</td>
<td>$ 0</td>
</tr>
<tr>
<td><strong>Non Federal Total of Individuals Served</strong></td>
<td>$ 482,901</td>
<td>$ 14,682</td>
</tr>
</tbody>
</table>

**Federal State MCH Block Grant Partnership Total**

$ 1,022,901 $ 384,712
Form Notes For Form 3a:
None

Field Level Notes for Form 3a:
None

Data Alerts: None
## II. TYPES OF SERVICES

### IIA. Federal MCH Block Grant

1. **Direct Services**  
   - A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One  
   - B. Preventive and Primary Care Services for Children  
   - C. Services for CSHCN  
2. **Enabling Services**  
3. **Public Health Services and Systems**  
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  
   - Physician/Office Services  
   - Hospital Charges (Includes Inpatient and Outpatient Services)  
   - Dental Care (Does Not Include Orthodontic Services)  
   - Durable Medical Equipment and Supplies  
   - Laboratory Services  

<table>
<thead>
<tr>
<th>Service</th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td></td>
<td>$162,901</td>
</tr>
<tr>
<td>Physician/Office Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Care</td>
<td>$60,000</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$40,000</td>
<td></td>
</tr>
<tr>
<td>Laboratory Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Services Total</td>
<td></td>
<td>$262,901</td>
</tr>
<tr>
<td><strong>Federal Total</strong></td>
<td>$600,000</td>
<td>$482,901</td>
</tr>
</tbody>
</table>
### IIB. Non-Federal MCH Block Grant

1. Direct Services
   - A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One:
     - Non-Federal: $114,000
     - Federal: $100,000
   - B. Preventive and Primary Care Services for Children:
     - Non-Federal: $100,000
     - Federal: $77,124
   - C. Services for CSHCN:
     - Non-Federal: $100,000
     - Federal: $86,300

2. Enabling Services
   - Non-Federal: $100,000
   - Federal: $52,020

3. Public Health Services and Systems
   - Non-Federal: $120,000
   - Federal: $109,980

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
   - Physician/Office Services
   - Hospital Charges (Includes Inpatient and Outpatient Services)
   - Dental Care (Does Not Include Orthodontic Services)
   - Durable Medical Equipment and Supplies
   - Laboratory Services

   **Direct Services Total**: $263,424

   **Non-Federal Total**: $534,000
   **Federal Total**: $425,424
Form Notes For Form 3b:
None

Field Level Notes for Form 3b:
None
Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated
State: American Samoa

Total Births by Occurrence 1,072

1a. Core RUSP Conditions

<table>
<thead>
<tr>
<th>Program Name</th>
<th>(A) Number Receiving at Least One Screen</th>
<th>(B) Number Presumptive Positive Screens</th>
<th>(C) Number Confirmed Cases</th>
<th>(D) Number Referred for Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical congenital heart disease</td>
<td>100 (9.3%)</td>
<td>20</td>
<td>11</td>
<td>11 (100.0%)</td>
</tr>
</tbody>
</table>

1b. Secondary RUSP Conditions
None

2. Other Newborn Screening Tests

<table>
<thead>
<tr>
<th>Program Name</th>
<th>(A) Number Receiving at Least One Screen</th>
<th>(B) Number Presumptive Positive Screens</th>
<th>(C) Number Confirmed Cases</th>
<th>(D) Number Referred for Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Hearing</td>
<td>1,045 (97.5%)</td>
<td>0</td>
<td>0</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

3. Screening Programs for Older Children & Women
None

4. Long-Term Follow-Up
No NBS conducted currently for American Samoa except for New Born Hearing Screenings. The MCH leaders with LBJ pediatricians, EHDI manager and other local partners will be working on finalizing plan for implementing the NBS.

For NB Hearing Screening when a child does not pass their hearing screening, they are referred to the Early Intervention Program, Part C and are also placed on Audiological Evaluation (AE) queue in SILAS (data system) for the Audiologists/program.
Form Notes For Form 4:

Currently, NBS has not been implemented yet for American Samoa. MCH leaders with LBJ Pediatricians and NB Hearing Screening Manager are working on the plan.

Field Level Notes for Form 4:

<table>
<thead>
<tr>
<th></th>
<th>Field Name:</th>
<th>Newborn Hearing - Receiving At Lease One Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fiscal Year:</td>
<td>2014</td>
</tr>
<tr>
<td></td>
<td>Column Name:</td>
<td>Other Newborn</td>
</tr>
</tbody>
</table>

Field Note:
The # reported by EHDI that were screened out of the 1,072 live births due to the following reasons:

- 7 inpatient deaths
- 15 missed/discharged without screening (4 screened outpatient and passed)
- 5 unable to screen (baby sensitive to screening equipment). So they were referred to have an Audiologist to conduct test/screen.
### Form 5a

**Unduplicated Count of Individuals Served under Title V**

**State:** American Samoa

**Reporting Year 2014**

<table>
<thead>
<tr>
<th>Types Of Individuals Served</th>
<th>(A) Title V Total Served</th>
<th>(B) Title XIX %</th>
<th>(C) Title XXI %</th>
<th>(D) Private / Other %</th>
<th>(E) None %</th>
<th>(F) Unknown %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>1,067</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>100.0</td>
</tr>
<tr>
<td>2. Infants &lt; 1 Year of Age</td>
<td>1,072</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>100.0</td>
</tr>
<tr>
<td>3. Children 1 to 22 Years of Age</td>
<td>12,212</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>100.0</td>
</tr>
<tr>
<td>4. Children with Special Health Care Needs</td>
<td>331</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>100.0</td>
</tr>
<tr>
<td>5. Others</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14,682</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Form Notes For Form 5a:**

None

**Field Level Notes for Form 5a:**

<table>
<thead>
<tr>
<th></th>
<th>Field Name:</th>
<th>Fiscal Year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Children 1 to 22 Years of Age</td>
<td>2014</td>
</tr>
<tr>
<td></td>
<td><strong>Field Note:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Estimate # of children seen in the schools for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dental screening, school outreaches, HV program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and at the Community Health Centers.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Field Name:</th>
<th>Fiscal Year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Children with Special Health Care Needs</td>
<td>2014</td>
</tr>
<tr>
<td></td>
<td><strong>Field Note:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td># of CYSCHN that were served by MCH for 2014.</td>
<td></td>
</tr>
</tbody>
</table>
Form 5b
Total Recipient Count of Individuals Served by Title V
State: American Samoa

Reporting Year 2014

<table>
<thead>
<tr>
<th>Types Of Individuals Served</th>
<th>Total Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>1,067</td>
</tr>
<tr>
<td>2. Infants &lt; 1 Year of Age</td>
<td>1,072</td>
</tr>
<tr>
<td>3. Children 1 to 22 Years of Age</td>
<td>12,212</td>
</tr>
<tr>
<td>4. Children with Special Health Care Needs</td>
<td>331</td>
</tr>
<tr>
<td>5. Others</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14,682</strong></td>
</tr>
</tbody>
</table>
Form Notes For Form 5b:
None

Field Level Notes for Form 5b:
None
### Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: American Samoa

Reporting Year 2014

## I. Unduplicated Count by Race

<table>
<thead>
<tr>
<th></th>
<th>(A) Total All Races</th>
<th>(B) White</th>
<th>(C) Black or African American</th>
<th>(D) American Indian or Native Alaskan</th>
<th>(E) Asian</th>
<th>(F) Native Hawaiian or Other Pacific Islander</th>
<th>(G) More than One Race Reported</th>
<th>(H) Other &amp; Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Deliveries</td>
<td>1,072</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>75</td>
<td>997</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>in State</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title V Served</td>
<td>1,072</td>
<td>0</td>
<td>0</td>
<td>75</td>
<td>997</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Eligible for Title</td>
<td>997</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>997</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>XIX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Total Infants in</td>
<td>1,072</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>75</td>
<td>997</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>State</td>
<td>Title V Served</td>
<td>1,072</td>
<td>0</td>
<td>0</td>
<td>75</td>
<td>997</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Eligible for Title</td>
<td>997</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>997</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>XIX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## II. Unduplicated Count by Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>(A) Total Not Hispanic or Latino</th>
<th>(B) Total Hispanic or Latino</th>
<th>(C) Ethnicity Not Reported</th>
<th>(D) Total All Ethnicities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Deliveries</td>
<td>1,072</td>
<td>0</td>
<td>0</td>
<td>1,072</td>
</tr>
<tr>
<td></td>
<td>in State</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title V Served</td>
<td>1,072</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Eligible for Title XIX</td>
<td>997</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Total Infants in</td>
<td>1,072</td>
<td>0</td>
<td>0</td>
<td>1,072</td>
</tr>
<tr>
<td>State</td>
<td>Title V Served</td>
<td>1,072</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Eligible for Title XIX</td>
<td>997</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data
State: American Samoa

<table>
<thead>
<tr>
<th>Application Year 2016</th>
<th>Reporting Year 2014</th>
</tr>
</thead>
</table>

### A. State MCH Toll-Free Telephone Lines

1. State MCH Toll-Free "Hotline" Telephone Number
   - (684) 699-0617
   - (684) 699-4606

2. State MCH Toll-Free "Hotline" Name
   - MCH Helpline
   - MCH Helpline

3. Name of Contact Person for State MCH "Hotline"
   - Dr. Anaise Uso
   - Aileen Solaita

4. Contact Person's Telephone Number
   - (684) 633-4623
   - (684) 733-1904

5. Number of Calls Received on the State MCH "Hotline"
   - 1,300

### B. Other Appropriate Methods

1. Other Toll-Free "Hotline" Names
2. Number of Calls on Other Toll-Free "Hotlines"
3. State Title V Program Website Address
   - mch-asdoh.org

4. Number of Hits to the State Title V Program Website
5. State Title V Social Media Websites
   - MCHAmericansamoa

6. Number of Hits to the State Title V Program Social Media Websites
### 1. Title V Maternal and Child Health (MCH) Director

<table>
<thead>
<tr>
<th>Name</th>
<th>Margaret Sesepasara</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Director of Nursing Division</td>
</tr>
<tr>
<td>Address 1</td>
<td>PO Box 5666</td>
</tr>
<tr>
<td>Address 2</td>
<td>MCH Program</td>
</tr>
<tr>
<td>City / State / Zip Code</td>
<td>Pago Pago / AS / 96799</td>
</tr>
<tr>
<td>Telephone</td>
<td>(684) 633-4606</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:msesepasara@doh.as">msesepasara@doh.as</a></td>
</tr>
</tbody>
</table>

### 2. Title V Children with Special Health Care Needs (CSHCN) Director

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr. Anaise Uso</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Acting MCH Program Coordinator</td>
</tr>
<tr>
<td>Address 1</td>
<td>PO Box 5666</td>
</tr>
<tr>
<td>Address 2</td>
<td>MCH Program</td>
</tr>
<tr>
<td>City / State / Zip Code</td>
<td>Pago Pago / AS / 96799</td>
</tr>
<tr>
<td>Telephone</td>
<td>(684) 699-4623 x28</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:anaise@doh.as">anaise@doh.as</a></td>
</tr>
</tbody>
</table>

### 3. State Family or Youth Leader (Optional)

<table>
<thead>
<tr>
<th>Name</th>
<th>Ipuniuesea Eliapo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>RHD Coordinator</td>
</tr>
<tr>
<td>Address 1</td>
<td>PO Box 5666</td>
</tr>
<tr>
<td>Address 2</td>
<td>MCH Program</td>
</tr>
<tr>
<td>City / State / Zip Code</td>
<td>Pago Pago / AS / 96799</td>
</tr>
<tr>
<td>Telephone</td>
<td>(684) 699-4623 x26</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:ieliapo@doh.as">ieliapo@doh.as</a></td>
</tr>
</tbody>
</table>
Form Notes For Form 8:

None
# List of MCH Priority Needs

**State:** American Samoa  
**Application Year:** 2016

**Priority Need Types:**
- **Continued:** Priorities from previous years.
- **New:** Priorities not included in previous years.

<table>
<thead>
<tr>
<th>No.</th>
<th>Priority Need</th>
<th>Priority Need Type (New, Replaced or Continued)</th>
<th>Rationale if priority need does not have a corresponding State or National Performance/Omeg Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Increase Breastfeeding babies at 3 months and 6 months of age.</td>
<td>Continued</td>
<td>Perinatal/Infant's Health</td>
</tr>
<tr>
<td>2.</td>
<td>Reduce infant mortality rate.</td>
<td>New</td>
<td>Perinatal/Infant's Health</td>
</tr>
<tr>
<td>3.</td>
<td>Reduce Childhood Obesity.</td>
<td>Continued</td>
<td>Child Health</td>
</tr>
<tr>
<td>4.</td>
<td>Promote oral health in all 6 domains.</td>
<td>Continued</td>
<td>Life Course/Cross Cutting</td>
</tr>
<tr>
<td>5.</td>
<td>Improve system of care for CYSHCN.</td>
<td>Continued</td>
<td>CYSHCN</td>
</tr>
<tr>
<td>6.</td>
<td>Promote evidence based developmental screenings for children 0-5 years of age.</td>
<td>New</td>
<td>Child Health</td>
</tr>
<tr>
<td>7.</td>
<td>Increase Access and Awareness to Adequate Prenatal Care.</td>
<td>Continued</td>
<td>Women's/Maternal Health</td>
</tr>
<tr>
<td>8.</td>
<td>Reduce Acute Rheumatic Fever and Rheumatic Heart Disease.</td>
<td>New</td>
<td>Life Course/Cross Cutting</td>
</tr>
<tr>
<td>9.</td>
<td>Increase Immunization Coverage Rates.</td>
<td>Continued</td>
<td>Adolescent</td>
</tr>
<tr>
<td>10.</td>
<td>Prevent adolescents from being bullied or bullying others.</td>
<td>Continued</td>
<td>Adolescent Health</td>
</tr>
</tbody>
</table>
Form Notes For Form 9:

None

Field Level Notes for Form 9:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Field Note:</td>
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<table>
<thead>
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<th>Priority Need 2</th>
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</thead>
<tbody>
<tr>
<td>Field Note:</td>
<td></td>
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</tbody>
</table>

Field Note:  
Also chosen as one of the top 10 needs for American Samoa to be considered for the next 5 years.

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<thead>
<tr>
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<th>Priority Need 3</th>
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<tbody>
<tr>
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<table>
<thead>
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<th>Priority Need 4</th>
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<td>Field Note:</td>
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<table>
<thead>
<tr>
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<th>Priority Need 5</th>
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<tbody>
<tr>
<td>Field Note:</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Field Name:</th>
<th>Priority Need 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Note:</td>
<td></td>
</tr>
</tbody>
</table>

Field Note:  
There is no clear data to show that developmental screenings tools are used by all medical providers in the territory for the children and adolescent population. There is current Policies and Procedures in place to provide Bright Futures in Practice Curriculum at the Well Baby/Child Clinics for ages 0-3 years by utilizing At-Risk Screening tools (Oral Health) and Participatory Guidance for various age-groups. Unfortunately, there is no current data to populate how many were identified at-risk or diagnosed with any developmental delay or disability characteristics. There is also no current data or reported number of referrals done and how many were treated/served/issues addressed.

<table>
<thead>
<tr>
<th>Field Name:</th>
<th>Priority Need 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Note:</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Field Name:</th>
<th>Priority Need 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Note:</td>
<td></td>
</tr>
</tbody>
</table>

Page 113 of 191 pages
Field Note:
Current Data shows the need for increasing access to services to prevent Acute Rheumatic Fever in order to reduce the high rate of Rheumatic Heart Disease.

Field Name:
Priority Need 9

Field Note:

Field Name:
Priority Need 10

Field Note:
Form Notes for Form 10a NPMs and NOMs:
Data not yet finalized by epidemiologist and pending Immunization for accurate confirmed #s.

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester
FAD Not Available for this measure.

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
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<td>34.8</td>
</tr>
<tr>
<td>Numerator</td>
<td>371</td>
</tr>
<tr>
<td>Denominator</td>
<td>1,067</td>
</tr>
<tr>
<td>Data Source</td>
<td>CHC</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-1 Notes:
Denominator is based on the # of prenatal care patients who came through the community health centers as Epidemiologist is not capable to get # from LBJ. Numerator is the # of women that came out to the clinics for rental care in the first trimester.

Data Alerts: None
NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations

FAD Not Available for this measure.

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Numerator</td>
<td>1</td>
</tr>
<tr>
<td>Denominator</td>
<td>1,072</td>
</tr>
<tr>
<td>Data Source</td>
<td>DOH-HIS</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-2 Notes:
None

Data Alerts: None
NOM-3 Maternal mortality rate per 100,000 live births

FAD Not Available for this measure.

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
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</tr>
<tr>
<td>Numerator</td>
<td>1</td>
</tr>
<tr>
<td>Denominator</td>
<td>1,072</td>
</tr>
<tr>
<td>Data Source</td>
<td>DOH-HIS</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-3 Notes:
This annual indicator of 93.3 is slightly below the value of 100 previously measured ans shows a slight decrease from data previously recorded.

Data Alerts: None
**NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)**

**Data Source:** National Vital Statistics System (NVSS)

### Multi-Year Trend

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Indicator</th>
<th>Standard Error</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>3.3 %</td>
<td>0.6 %</td>
<td>36</td>
<td>1,077</td>
</tr>
<tr>
<td>2012</td>
<td>5.3 %</td>
<td>0.7 %</td>
<td>61</td>
<td>1,163</td>
</tr>
<tr>
<td>2011</td>
<td>4.3 %</td>
<td>0.6 %</td>
<td>54</td>
<td>1,255</td>
</tr>
<tr>
<td>2010</td>
<td>3.7 %</td>
<td>0.5 %</td>
<td>46</td>
<td>1,234</td>
</tr>
<tr>
<td>2009</td>
<td>2.7 %</td>
<td>0.4 %</td>
<td>36</td>
<td>1,340</td>
</tr>
</tbody>
</table>

**Legends:**
- 📈 Indicator has a numerator <10 and is not reportable
- ⚠️ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

### State Provided Data

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
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<tr>
<td>Numerator</td>
<td>37</td>
</tr>
<tr>
<td>Denominator</td>
<td>1,072</td>
</tr>
<tr>
<td>Data Source</td>
<td>DOH-HIS</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

**NOM-4.1 Notes:**

None

**Data Alerts:** None
NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Indicator</th>
<th>Standard Error</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>2012</td>
<td>0.9 %</td>
<td>0.3 %</td>
<td>10</td>
<td>1,163</td>
</tr>
<tr>
<td>2011</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>2010</td>
<td>NR</td>
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<tr>
<td>2009</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
</tbody>
</table>

Legends:
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State Provided Data

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
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</table>

Data Source

- DOH HIS

Data Source Year

- 2014

NOM-4.2 Notes:

None

Data Alerts: None
NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)
Data Source: National Vital Statistics System (NVSS)

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Indicator</th>
<th>Standard Error</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2.9 %</td>
<td>0.5 %</td>
<td>31</td>
<td>1,077</td>
</tr>
<tr>
<td>2012</td>
<td>4.4 %</td>
<td>0.6 %</td>
<td>51</td>
<td>1,163</td>
</tr>
<tr>
<td>2011</td>
<td>3.6 %</td>
<td>0.5 %</td>
<td>45</td>
<td>1,255</td>
</tr>
<tr>
<td>2010</td>
<td>3.0 %</td>
<td>0.5 %</td>
<td>37</td>
<td>1,234</td>
</tr>
<tr>
<td>2009</td>
<td>2.5 %</td>
<td>0.4 %</td>
<td>34</td>
<td>1,340</td>
</tr>
</tbody>
</table>

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data

<table>
<thead>
<tr>
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<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
<td>3.4</td>
</tr>
<tr>
<td>Numerator</td>
<td>36</td>
</tr>
<tr>
<td>Denominator</td>
<td>1,072</td>
</tr>
<tr>
<td>Data Source</td>
<td>DOH HIS</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-4.3 Notes:
None

Data Alerts: None
NOM-5.1 Percent of preterm births (<37 weeks)

**FAD Not Available for this measure.**

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
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<td>DOH-HIS</td>
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<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
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</table>

**NOM-5.1 Notes:**

None

**Data Alerts:** None
NOM-5.2 Percent of early preterm births (<34 weeks)

FAD Not Available for this measure.

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
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<td>Data Source</td>
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<tr>
<td>Data Source Year</td>
<td>2014</td>
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</table>

NOM-5.2 Notes:
None

Data Alerts: None
NOM-5.3 Percent of late preterm births (34-36 weeks)

**FAD Not Available for this measure.**

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</thead>
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<tr>
<td>Data Source Year</td>
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</tbody>
</table>

**NOM-5.3 Notes:**

None

**Data Alerts:** None
NOM-6 Percent of early term births (37, 38 weeks)

FAD Not Available for this measure.

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<tr>
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<tr>
<td>Data Source Year</td>
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</tbody>
</table>

NOM-6 Notes:
None

Data Alerts: None
NOM-7 Percent of non-medically indicated early elective deliveries

FAD Not Available for this measure.

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<tr>
<th>State Provided Data</th>
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</tr>
</thead>
<tbody>
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<td>Data Source</td>
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</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-7 Notes:
This data will not be available until later in the year. DOH Epi was not able to get this data in time of report.

Data Alerts: None
NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths
Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Indicator</th>
<th>Standard Error</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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Legends:
- ⚠ Indicator has a numerator <10 and is not reportable
- ⚫ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

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<td>Denominator</td>
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<tr>
<td>Data Source</td>
<td>DOH-HIS</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
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</tbody>
</table>

NOM-8 Notes:
This annual indicator has been adjusted since the original 2016 application.

Data Alerts: None
NOM-9.1 Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

### Multi-Year Trend

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Indicator</th>
<th>Standard Error</th>
<th>Numerator</th>
<th>Denominator</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>9.3</td>
<td>3.0%</td>
<td>10</td>
<td>1,077</td>
</tr>
<tr>
<td>2012</td>
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<td>NR</td>
</tr>
<tr>
<td>2011</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>2010</td>
<td>11.4</td>
<td>3.1%</td>
<td>14</td>
<td>1,234</td>
</tr>
<tr>
<td>2009</td>
<td>11.2</td>
<td>2.9%</td>
<td>15</td>
<td>1,340</td>
</tr>
</tbody>
</table>

**Legends:**
- 📊 Indicator has a numerator <10 and is not reportable
- ⭕️ Indicator has a numerator <20 and should be interpreted with caution

### State Provided Data

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<thead>
<tr>
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</thead>
<tbody>
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</tr>
<tr>
<td>Denominator</td>
<td>1,072</td>
</tr>
<tr>
<td>Data Source</td>
<td>DOH-HIS</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

**NOM-9.1 Notes:**
This annual indicator has been adjusted since the original 2016 application.

**Data Alerts:** None
## NOM-9.2 Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

### Multi-Year Trend

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Indicator</th>
<th>Standard Error</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
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<td>2013</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>2012</td>
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<tr>
<td>2009</td>
<td>NR</td>
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**Legends:**
- ⚠️ Indicator has a numerator <10 and is not reportable
- ⭕️ Indicator has a numerator <20 and should be interpreted with caution

### State Provided Data

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### NOM-9.2 Notes:

This annual indicator has been adjusted since the original 2016 application.

### 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

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**Legends:**
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**NOM-9.3 Notes:**

This annual indicator has been adjusted since the original 2016 application.

**Data Alerts:** None
### NOM-9.4 Preterm-related mortality rate per 100,000 live births

**FAD Not Available for this measure.**

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**NOM-9.4 Notes:**

This annual indicator has been adjusted since the original 2016 application.

**Data Alerts:** None
NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

### Multi-Year Trend

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<tr>
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**Legends:**
- 📊 Indicator has a numerator <10 and is not reportable
- 🔄 Indicator has a numerator <20 and should be interpreted with caution

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<td>Data Source Year</td>
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</table>

**NOM-9.5 Notes:**
1 case confirmed death from SUID.

**Data Alerts:** None
NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

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NOM-10 Notes:
None

Data Alerts: None
NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

FAD Not Available for this measure.

NOM-11 Notes:
These #s were not available from DOH Epidemiologist in time of report.

Data Alerts: None
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)

**FAD Not Available for this measure.**

**NOM-12 Notes:**

None

**Data Alerts:** None
NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

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 12 months

FAD Not Available for this measure.

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NOM-14 Notes:
Denominator is based on 2013 Statistical Yearbook Data Numerator is based on Dental Team outreach.

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

<table>
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<tr>
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**Legends:**
- NR: Indicator has a numerator <10 and is not reportable
- #: Indicator has a numerator <20 and should be interpreted with caution

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**NOM-15 Notes:**
This annual indicator has been adjusted since the original 2016 application by DOH Epidemiologist.

**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

<table>
<thead>
<tr>
<th>Year</th>
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<th>Standard Error</th>
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**NOM-16.1 Notes:**
This annual indicator has been adjusted since the original 2016 application by DOH Epidemiologist.

**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

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<tr>
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**NOM-16.2 Notes:**
No adolescent motor vehicle mortality rate reported by DOH Epi.

**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

<table>
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<tr>
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**NOM-16.3 Notes:**
No adolescent suicide reported per DOH Epidemiologist.

**Data Alerts:** None
NOM-17.1 Percent of children with special health care needs

FAD Not Available for this measure.

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<td>Data Source Year</td>
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NOM-17.1 Notes:
None

Data Alerts: None
NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

FAD Not Available for this measure.

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NOM-17.2 Notes:
None

Data Alerts: None
NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

FAD Not Available for this measure.

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NOM-17.3 Notes:
None

Data Alerts: None
NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

**FAD Not Available for this measure.**

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<td>Data Source Year</td>
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**NOM-17.4 Notes:**

None

**Data Alerts:** None
NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

FAD Not Available for this measure.

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NOM-18 Notes:
None

Data Alerts: None
NOM-19 Percent of children in excellent or very good health

FAD Not Available for this measure.

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NOM-19 Notes:
None

Data Alerts: None
NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

FAD Not Available for this measure.

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**NOM-20 Notes:**
None

**Data Alerts:** None
NOM-21 Percent of children without health insurance

FAD Not Available for this measure.

NOM-21 Notes:
Numerator is based on the # of those with no health insurance as collected by clinics and home visiting enrollment. Even if people were on medicaid, they do not understand that they may have medicaid.

Data Alerts: None

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</table>
NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

FAD Not Available for this measure.

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<td>Data Source</td>
<td>Immunization</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-22.1 Notes:
This data was not ready in time of report from the Immunization Program.

Data Alerts: None
NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

FAD Not Available for this measure.

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
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</tr>
<tr>
<td>Annual Indicator</td>
<td>50.0</td>
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<tr>
<td>Numerator</td>
<td>12,593</td>
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<tr>
<td>Denominator</td>
<td>25,186</td>
</tr>
<tr>
<td>Data Source</td>
<td>DOH-HIS, Immunization</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-22.2 Notes:
Still pending actual confirmed # from Immunization program, however, this was estimate based on immunization program.

Data Alerts: None
NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

FAD Not Available for this measure.

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
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</tr>
<tr>
<td>Numerator</td>
<td>589</td>
</tr>
<tr>
<td>Denominator</td>
<td>10,679</td>
</tr>
<tr>
<td>Data Source</td>
<td>DOH-HIS, Immunization</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-22.3 Notes:
This data is pending accurate confirmed #s from Immunization program; this is an estimate. HPV still lacks awareness in the community.

Data Alerts: None
NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

FAD Not Available for this measure.

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
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</tr>
<tr>
<td>Numerator</td>
<td>5,873</td>
</tr>
<tr>
<td>Denominator</td>
<td>10,679</td>
</tr>
<tr>
<td>Data Source</td>
<td>DOH-HIS, Immunization</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-22.4 Notes:
Accurate confirmed # pending Immunization program. This is an estimate based on what Immunization has done.

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

FAD Not Available for this measure.

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
<td>55.0</td>
</tr>
<tr>
<td>Numerator</td>
<td>5,873</td>
</tr>
<tr>
<td>Denominator</td>
<td>10,679</td>
</tr>
<tr>
<td>Data Source</td>
<td>DOH-HIS, Immunization</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-22.5 Notes:
Accurate confirmed # pending immunization. This is an estimate based on the work they have done.

Data Alerts: None
NPM-1 Percent of women with a past year preventive medical visit

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

NPM-3 Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>50.0</td>
<td>49.0</td>
<td>48.0</td>
<td>47.0</td>
<td>46.0</td>
</tr>
</tbody>
</table>

NPM-6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>1.0</td>
<td>5.0</td>
<td>10.0</td>
<td>15.0</td>
<td>20.0</td>
</tr>
</tbody>
</table>

NPM-8 Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>
### NPM-9 Percent of adolescents, ages 12 through 17, who are bullied or who bully others

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>80.0</td>
<td>60.0</td>
<td>40.0</td>
<td>20.0</td>
<td>10.0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>20.0</td>
<td>30.0</td>
<td>50.0</td>
<td>70.0</td>
<td>80.0</td>
</tr>
</tbody>
</table>

### NPM-11 Percent of children with and without special health care needs having a medical home

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>30.0</td>
<td>31.0</td>
<td>32.0</td>
<td>33.0</td>
<td>34.0</td>
</tr>
</tbody>
</table>

### NPM-13 A) Percent of women who had a dental visit during pregnancy

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>2.0</td>
<td>4.0</td>
<td>6.0</td>
<td>8.0</td>
<td>10.0</td>
</tr>
</tbody>
</table>

### NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>5.0</td>
<td>10.0</td>
<td>15.0</td>
<td>20.0</td>
<td>25.0</td>
</tr>
</tbody>
</table>
States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.
States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.
Form Notes for Form 10d NPMs and SPMs

No newborn screenings done for the past years. 2013, the tests were discussed 2014, the tests again were discussed but pending meeting with Director and other senior leaders. Now, NB hearing screening manager and Title V coordinator and MCH Division Head and LBJ pediatricians are talking again to finalize plan. Seeking also advice from off island for the screenings and goal is to implement within this coming fiscal year. As for NPM#2 to 6: CSHCN team served 331 Children and youth with special health care needs from 0 to 21 year old. Only 102 were surveyed face to face and were from 0 to 18 years old. NPM#10: No deaths from motor vehicle crashes for this age group.

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>30.0</td>
<td>30.0</td>
</tr>
<tr>
<td>Annual Indicator</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>1,287</td>
<td>1,175</td>
<td>1,164</td>
<td>1,072</td>
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</tr>
<tr>
<td>Data Source</td>
<td>Newborn records</td>
<td>Newborn record</td>
<td>NewBorn Record</td>
<td>New Born Record</td>
<td></td>
</tr>
<tr>
<td>Provisional Or Final ?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Provisional</td>
</tr>
</tbody>
</table>

Field Level Notes for Form 10d NPMs:

1. Field Name: 2015
   Field Note:
   Hope to implement NB Screening sometimes in the new fiscal year.

2. Field Name: 2014
   Field Note:
   Currently, American Samoa has not implemented Newborn Screenings. Issue were discussed and hope to implement it in fiscal year 2015; however, NB Hearing Screening manager, Title V Coordinator and MCH Division Head and LBJ pediatricians are working to finalize plan for fy2015. Reporting as 1 as I can't seem to bypass with numerator "0"

3. Field Name: 2013
Field Note:
Currently American Samoa still does not conduct newborn metabolic screenings but is in the phase of gathering information with lab off island on how AS can go about conducting such tests and send specimen for analyzing as AS LBJ Lab is not capable to conduct such testing. However, EHDI program continues to do on going hearing screenings for newborns before hospital discharge. EHDI reported that out of the 1,164 new borns for 2013, 1,157 (99.4%) of newborns had a hearing screen before discharge and from those 1s time screenings, only 2 (0.2% of inpatient services) were referred for a 2nd testing or further assessment. MCH program coordinator is working with the DOH Lab Manager and LBJ pediatricians in finding a way and looking into fund that may be available to provide such testing of newborns of American Samoa as it can detect early any developmental delay or disability that may be prevented from getting worse. After the Infant Mortality CoIN Summit in August, American Samoa Team has agreed to implement NBS for American Samoa and goal is to have it implemented by January 2015. Director of Health, Deputy Director of Health with LBJ Pediatricians are all in agreement in working towards meeting this goal. There was a plan that was mentioned to current MCH coordinator that was brought forward; however, nothing was done and MCH wasn’t pushing for it in the past. So currently, we have arranged for a meeting with LBJ pediatricians who had the plan 2 years ago to share plan with MCH and DOH and from there we can see if there are any changes that need to be made or add and then plan can be presented to Director and other key leaders and then to the Governor and Legislature.

<table>
<thead>
<tr>
<th>4.</th>
<th>Field Name:</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Note:</td>
<td></td>
<td>NA - American Samoa does not have a state mandated newborn screening program. In Form 6, a total number of 1159 infants (98.6% of live births) were screened for Hearing. This is a great achievement compared to last year's data (approximately 8% increase).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.</th>
<th>Field Name:</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Note:</td>
<td></td>
<td>NA - American Samoa does not have a state mandated newborn screening program. In Form 6, a total number of 1171 infants (90.8% of live births) were screened for Hearing.</td>
</tr>
</tbody>
</table>

Data Alerts: None
NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
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<td>90.0</td>
<td>90.0</td>
<td>70.0</td>
<td>71.0</td>
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<tr>
<td>Annual Indicator</td>
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<td>88.6</td>
<td>51.2</td>
<td>65.7</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>39</td>
<td>39</td>
<td>22</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>44</td>
<td>44</td>
<td>43</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Data Source</td>
<td>CSHCN Program Survey</td>
<td>CSHCN Program Survey</td>
<td>CSCHN Survey</td>
<td>CSCHN Survey</td>
<td>Provisional</td>
</tr>
<tr>
<td>Provisional Or Final ?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   **Field Note:**
   This year, CYSHCN was able to serve 331 clients. Out of the 331, the team was able to conduct 102 surveys (30.8% of total clients) face to face. Out of the 102 surveys, 67 participants (65.7% surveyed) were satisfied with the services their children received.

2. **Field Name:** 2013
   **Field Note:**
   The CSHCN survey is currently being conducted where there’s was 43 surveys that were completed in time of reporting; however, based on the list of clients submitted by CSN OT there is a total of 200 CSN clients referred to MCH CSN program as of September 2014. Out of the 200 clients, there are some that staff have found out are no longer on the island and some have moved location or even passed away.

   Based on the list, MCH is hoping to at least conduct 100 of those survey. 43 surveys that have been completed and these surveys were conducted face to face. The denominator is based on actual surveys completed during time of reporting and numerator is based those who felt satisfied with services that were conducted by MCH. Surveys are currently being continued and will also during this time will verify if all the 200 clients that were referred to MCH are still on island or not.

   The drop in numbers is because these surveys were conducted face to face where MCH felt that a more accurate respond will be captured rather than the phone survey where majority of the family said they were satisfied with services but in reality, they were not. It could be for the reason they don't want to have to explain themselves on the phone. But with the face to face surveys, this is more accurate picture of how our parents felt about services their special needs child have received from MCH.

3. **Field Name:** 2011
   **Field Note:**
   
Page 160 of 191 pages
Field Note:
This data is an estimate based on the survey carried out in 2009 by the Children and Youth with Special Health Care Needs Staff. The MCH Program recently obtained an additional staff on a temporary basis, Ms Gaase, who is currently conducting the survey by telephone. If the results are in by the time this application is due then this data will be revised and edit.

Data Alerts: None
NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
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<td>81.0</td>
<td>80.0</td>
<td>75.0</td>
<td>25.0</td>
</tr>
<tr>
<td>Annual Indicator</td>
<td>79.5</td>
<td>79.5</td>
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<tr>
<td>Numerator</td>
<td>35</td>
<td>35</td>
<td>22</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
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<td>44</td>
<td>43</td>
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<td>CSHCN Program</td>
<td>CSHCN Program</td>
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<td></td>
</tr>
<tr>
<td>Provisional Or Final ?</td>
<td>Provisional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   **Field Note:**
   Though we CYSHCN team saw 331 total. 102 were the ones that we surveyed who have had at least 2 visits within this year. These 102 surveys were conducted face to face instead of through phone.

2. **Field Name:** 2013
   **Field Note:**
   The CSHCN survey is currently being conducted where there was only 43 surveys completed during time of reporting; however, based on the list of clients submitted by CSN OT there is a total of 200 CSN clients referred to MCH CSN program as of september 2014. Out of the 200 clients, there are some that staff have found out are no longer on the island and some have changed location.

   Based on the list, MCH is hoping to at least conduct 100 of those surveys or 100% as the number of CSHCN is only 200. 43 surveys that have just been completed have shown also based on face to face surveys, those who replied they were somewhat satisfied or satisfied with program also were the ones that received ongoing, comprehensive and coordinated services from their medical home. Those who were not satisfied didn't.

   MCH will work to have an LBJ pediatrician that is skilled and experienced in serving CSHCN to conduct a session for all DOH and MCH physicians. In order for all DOH physician to serve our CSHCN and not discriminate them, they need to learn ways in providing services for them. This can be good for the physicians so that they will assist in making our CSHCN clients and their families feel comfortable and would like to take advantage of the use of clinics in the future.

3. **Field Name:** 2012
   **Field Note:**
   The denominator is the total number of clients that were interviewed. The total CSHCN population is 148 clients.

4. **Field Name:** 2011
Field Note:
The denominator is the total number of clients that were interviewed.

Data Alerts: None
NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>15.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Annual Indicator</td>
<td>100.0</td>
<td>100.0</td>
<td>11.6</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>44</td>
<td>44</td>
<td>5</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>44</td>
<td>44</td>
<td>43</td>
<td>102</td>
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</tr>
<tr>
<td>Data Source</td>
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<td>CSHCN Program</td>
<td>CSHCHN Program</td>
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<td>Provisional Or Final ?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Provisional</td>
</tr>
</tbody>
</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   **Field Note:**
   102 face to face surveys were conducted and 11 only identified they have adequate insurance to pay for services they need. Last year, it was phone survey.

2. **Field Name:** 2013
   **Field Note:**
   The CSHCN survey is currently being conducted where there were 43 surveys that were completed; however, based on the list of clients submitted by CSN OT there is a total of 200 CSN clients referred to MCH CSN program. Out of the 200 clients, there are some that staff have found out are no longer on the island and some have moved location.

   Based on the list, MCH is hoping to at least conduct 100 of those survey or 100% of the surveys. The 43 surveys that have just been completed in time of reporting shows a big drop in the amount of having adequate private or public insurance to pay for the services the child needs. It's different from phone survey again as people would rather say yes just to get over it and not answer truthfully. But the 43 face to face surveys is where concerns were shared and also the challenges families face is not having enough fund to pay for a CHSCN visit and or medical services. Though families are eligible medicaid; however, it is not enough to cover for additional services and extended services that these children need.

   Based on feedback from surveyors, majority of families have no insurance to pay for services but have solicit help from families and others to pay for services and resources needed for their child. Definite # will be reported once surveys are completed for needs assessment. In addition to that, the Community Health Centers charges $10 for a Dr's visit and that doesn't include medications. Even with the $10 fee, majority of the families are poor and still cannot afford at $10 payment for child to see the physician and on top of that they do not afford to pay for medications that the child may need.

**Data Alerts:** None
NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>75.0</td>
<td>87.0</td>
<td>88.0</td>
<td>40.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Annual Indicator</td>
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<td>86.4</td>
<td>25.6</td>
<td>15.7</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>38</td>
<td>38</td>
<td>11</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>44</td>
<td>44</td>
<td>43</td>
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</tr>
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<td></td>
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</tr>
</tbody>
</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   **Field Note:** Based on the face to face surveys for 102 clients, only 16 states the community based services systems are organized. If it was based on our services only, majority of our clients would rate yes; however, it is based on all services for the community such as SPED, Voc. Rehab, etc. they feel they are not getting the support from other services unless MCH CYSHCN team gets involved.

2. **Field Name:** 2013
   **Field Note:** The drop in % is based on the current face to face surveys that is still ongoing and based on the 43 surveys that have been completed, the % have decreased as again based on phone survey that was conducted in the previous year, people will answer yes to hurry up and complete survey. But in face to face survey, the reality of how families feel that are community based service systems are organized so they can use easily is not good. This is based on families going to the community centers to only find out that there is a shortage of physicians or physician is not capable or have knowledge in seeing a CSHCN. The drop also is based on the women's health clinic provider is also a CSHCN provider. The other reason is one of the community health center does not have handicap parking.

3. **Field Name:** 2012
   **Field Note:** Data is based on the 2011 survey.

4. **Field Name:** 2011
   **Field Note:** Data is based on the 2011 survey.

**Data Alerts:** None
NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

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</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   **Field Note:**
   2 youths that were served in 2014 graduated from high school and now have transitioned into adulthood. For 2014, 331 CSHCN were served and still being served under CYSHCN versus the 10 that was identified in 2013. However, the only ones that were surveyed in time of report came out to a total of 102 face to face surveys and they were in the age group of 18 years old and younger.

2. **Field Name:** 2013
   **Field Note:**
   Again current CSN survey is being conducted and there is not enough completed surveys to determine baseline but based on the denominator of 10 youths that were under CSN last year, only 2 were identified to have receive services necessary to make transitions into adult life within this reporting year; however, still received the necessary services to make transition to all aspect of adult life, including health care, work and independence. After grant review and presentation of grant review to Director of Health and MCH leaders, the OT and the new coordinator for CSN program will be working to make sure that our youths are transitioning to all aspects of adult life which include employment, continuing education, volunteering opportunity, health care, utilizing public transportation, preparing own meals, maintain personal belongings, managing finance and having a family of their own. Plans have been made to set meetings with all agencies involved with CSHCN such as OPAD, UCEDD and private companies to discuss areas they can assist in making our CSHCN become a part of the community and not feel they're being treated any different from everyone else.

3. **Field Name:** 2012
   **Field Note:**
   Data is based on the 2011 survey. None of the parents/caregivers reported that their 16 to 18 years old teen perceived that their child received any services to transition to adult life.

4. **Field Name:** 2011
   **Field Note:**
   Data is based on the 2011 survey. None of the parents/caregivers reported that their 16 to 18 years old teen perceived that their child received any services to transition to adult life.
Field Note:
None of the parents/caregivers reported that their 16 to 18 years old teen perceived that their child received any services to transition to adult life.

Data Alerts: None
NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

<table>
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</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   
   **Field Note:**
   Data source is from American Samoa Immunization Program, attained from their annual survey of 1,582 client records.

2. **Field Name:** 2013
   
   **Field Note:**
   This data was collected from the Immunization program. There is an increase in the number of children but a drop in the number of those who completed their full schedule of age appropriate immunizations for this age group. Data from Immunization WEBIZ where 1,994 fell in this age group from 19 to 35 months.
   
   There is an increase in # of children from 19 to 35 months; however a big drop in the numerator due to the following reasons:
   1) one of the densely populate area in the Central were not inputting data into WEBIZ database
   2) Families not bringing in their children for their shots on time.
   3) Transportation is a challenge.
   4) Poor customer service from Nurses serving the public.

   MCH will be utilizing a children services coordinate that can coordinate activities and creative ways that can encourage families or women to bring their children in the clinic for their shots on time.

**Data Alerts:** None
NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

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Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   **Field Note:**
   Data awaiting confirmation from Family Planning and DOH Epi.

2. **Field Name:** 2013
   **Field Note:**
   The number of new borns was from the HIS Office/LBJ and the number of teenage pregnancies were based on numbers from family planning and kotelchuck index cards. It is a positive accomplishment for American SAmoa as the rate has decreased.

   Though the number had decreased there is still a great concern that the number is still above 25% of total pregnancies are from teenagers. However, it is a step towards decreasing the rate every year. MCH has been conducting outreaches and going out into the communities and hope to decrease this rate every year.

3. **Field Name:** 2012
   **Field Note:**
   This data was reported from MCH Logbook for collecting Postpartum Cards. This log book has data currently used for calculating the Kotelchuck Index. LBJ Hospital's Labor and Delivery had reported 135 total pregnant teens but it is unsure if they all fell under the 15 to 17 yrs old range.

4. **Field Name:** 2011
   **Field Note:**
   This data is provisional and will be finalized once data is accurately determined.

Data Alerts: None
NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

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Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   **Field Note:**
   A total of 18 elementary schools (both private and public) were covered. A total number of 717 third grade students were screened in the school year 2013-2014. This is 66.7% of the total DOE enrollment of 1075 third grade students recorded in May 2014. Ninety percent (90%) of all third grade screened had at least one permanent molar sealed. By using the DOE enrollment number as the denominator, 60% was obtained as the annual indicator for this performance measure. More students were served but because there is an increase in denominator, the indicator dropped by 3%.

2. **Field Name:** 2013
   **Field Note:**
   Data reported by the MCH School Outreach team. A total of eighteen schools were covered in the school year 2013, out of a total of 37 elementary (1st to 8th grade) on the island.
   Though the rate may have increased; however the denominator has decreased as it is based on the total # of 3rd grade children attending the schools. The decrease in # of children served were based on children enrolled in 3rd graders and some schools had small census. So though more schools, but it was less students.

3. **Field Name:** 2012
   **Field Note:**
   Data reported by the MCH School Outreach Team also known as the MCH Dental team.

4. **Field Name:** 2011
   **Field Note:**
   Data reported by the MCH School Outreach Team.

**Data Alerts:** None
**NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.**

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**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2014
   **Field Note:**
   Numbers has not been finalized until later on this year. Pending confirming from DOH Epi (HIS office).

2. **Field Name:** 2013
   **Field Note:**
   Denominator is based on the 2010 Census and numerator based on DOH/HIS and LBJ data. There seems to be a constant # for the past years. The Territory has been doing a lot of outreaches also to inform people in regards to safe driving. MCH has been educating parents in making sure their children know safe ways of crossing the street. Also advising children in taking heed with who they catch ride with. Continued awareness in order for numbers to not increase.

3. **Field Name:** 2011
   **Field Note:**
   Denominator based on the American Samoa 2010 Census.

**Data Alerts:** None
### NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

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| **Provisional Or Final ?** | Final |

#### Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2013
   **Field Note:**
   Denominator based on # of women coming into the clinic who have given birth.
   Numerator is based on # of women WIC received that are still BF in the 6 months of age.
   This year, MCH and Breastfeeding Coordinator have been working together to push and encourage Breastfeeding and has showed a positive outlook that women are taking advantage of breastfeeding their child. This year, there were activities to promote breastfeeding, fairs and so forth and continuous education. So it is an accomplishment for MCH that BF rate have increased and hope to continue to increase in the future.

2. **Field Name:** 2012
   **Field Note:**
   The # of mothers who have BF their infants at 6 moths have decreased due to a lot of factors: fear of baby not being having enough vitamin and nutrients, fear of the unknown, and ack of awareness of BF benefits.

3. **Field Name:** 2011
   **Field Note:**
   Data reported is from the Well Baby Clinics of Leone and Amouli.

#### Data Alerts: None
### NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

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</table>

#### Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2013  
   **Field Note:**  
   Out of the 1,161 newborns, EHDI program was able to screen 1154 new borns and 2 of those new borns were referred for 2nd testing and further evaluation.  
   Date received from EHDI Program for Numerator  
   Denominator # from DOH/HIS & LBJ  
   There's an increase in the # of babies being screened for hearing and it's another accomplishment for the Territory of American Samoa and also the Hearing Screening Program.  
   MCH, Helping Babies Hear and MIECHV program are working hand in hand to capture babies that may have been missed or required 2nd testing to be brought back in for further testings.

2. **Field Name:** 2012  
   **Field Note:**  
   Data was provided by the Helping Babies Hear Early Hearing Detection and Intervention Program of American Samoa (EHDI). This program is under Department of Health.

3. **Field Name:** 2011  
   **Field Note:**  
   This numerator is based on the 2011 EHDI data, and the denominator was reported by the DOH - HIS.

**Data Alerts:** None
### NPM 13 - Percent of children without health insurance.

<table>
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<td></td>
<td>Provisional</td>
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</tbody>
</table>

### Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014  
   **Field Note:**  
   Numerator is based on the # of children coming into the health centers that have noted they are without health insurance and do not know that they are covered under Medicaid. Denominator is based on 2010 Census for children under 18 years. Though Medicaid covers 80% and more of the Territory's people, but a lot of them even parents would say they do not have any health insurance.

2. **Field Name:** 2013  
   **Field Note:**  
   AS does not have health insurance except for Medicaid presumptive eligibility in which a lump sum is given to LBJ for services provided for all children of AS. Currently, AS Governments is looking into option into the health insurance exchange but has been difficult because there are no third party health insurance available on the island nor any health insurance companies. Only insurance carried by insurance companies are life, death, auto and home.

3. **Field Name:** 2012  
   **Field Note:**  
   This measure is not applicable for American Samoa. American Samoa law mandates that all residents including children receive free medical services at the government hospital and Public Health, the only two health care providers in the Territory. All children are presumed eligible for Medicaid and SCHIP services. The only cost for healthcare are facility costs of $10 charged per visit at the hospital. This also includes all CHC dental and primary health clinics.

4. **Field Name:** 2011
Field Note:
This measure is not applicable for American Samoa. American Samoa law mandates that all residents including children receive free medical services at the government hospital and Public Health, the only two health care providers in the Territory. All children are presumed eligible for Medicaid and SCHIP services. The only cost for healthcare are facility costs of $10 charged per visit at the hospital. This also includes all CHC dental and primary health clinics.

Data Alerts: None
NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

<table>
<thead>
<tr>
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<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2013
   
   **Field Note:**
   Data received from WIC and land grant for analyzing data for WIC. There has been an increase for children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile and there are factors that contribute to that as some parents are still feeding their children with unhealthy foods such as soda, candies, chips, cookies especially when a lot of parents are always out in the community and participating in functions that the fast way to prepare a meal for the child is just to buy snacks.

   MCH plans to be stained at the WIC office to do more education for families on eating healthy and to prepare healthy foods for their children instead of buying snacks.

2. **Field Name:** 2012
   
   **Field Note:**
   Data was not available from WIC at the time of grant submission. Thus data reported is from the Community Health Center's Database. Once a more accurate data is provided, it will be updated on EHB.

3. **Field Name:** 2011
   
   **Field Note:**
   The indicator decreased from 36.5 to 32.7.

**Data Alerts:** None
NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

<table>
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Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014

   **Field Note:**
   Numerator based on data collected by DOH-HIS from community health center prenatal clinics. Denominator is the # of women delivering live births.

2. **Field Name:** 2013

   **Field Note:**
   Numerator: # of women that were referred to tobacco clinic for smoking in the last trimester from prenatal clinic log book.

   The % has decreased which is also important as mothers are recognizing the affect of smoking on their babies. MCH continue to also educate pregnant women before they are discharged from hospital in regards to this issue and also to pregnant women when they are coming in for their prenatal follow up visits.

   Constant reminder, education and awareness are what MCH continues to do in the health centers and the LBJ maternity and prenatal clinics.

**Data Alerts:** None
NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

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Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   **Field Note:** DOH-HIS awaiting confirmed # from LBJ.

2. **Field Name:** 2013
   **Field Note:**
   Denominator is from DOC 2010 Census.
   Numerator is # reported from DOH/HIS and LBJ.
   
   #s seem to fluctuate but the goal is "0" for every year.

   There were 2 attempted suicide and were not successful in the same year per Suicide Prevention Program.

   MCH continues to work in educating and making children aware about the importance of getting help when they feel they are getting pressured or feel out of place. There was a concern from one of the densely populated school in the Territory that shared that Bullying is a problem in the school but the public is not aware of. The cause of this suicide can be any factors which include: problems in the home, peer pressure and abuse.

3. **Field Name:** 2012
   **Field Note:**
   Zero number of suicide deaths were reported for youth aged 15 through 19.

4. **Field Name:** 2011
   **Field Note:**
   Denominator has been updated to the 2010 Census.

Data Alerts: None
NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

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</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   
   **Field Note:**
   There was one live birth with a weight less than 1,500 gm and that child was delivered at the only hospital which is LBJ that has a NICU. Again in 2013, now has confirmed there were 4 LBW in 2013 1 = 501 to 1000 grams 3 = 1001 to 1500 grams ALL 4 delivered at LBJ - only hospital.

2. **Field Name:** 2013
   
   **Field Note:**
   There are no facilities for high risk deliveries and neonates in AS except for the LBJ Delivery room for all deliveries and NICU. However, the # of live births weighing < 2500 grams = 33; and # of live births weighing < 1500 grams = 4 in 2013. Note: As of 2014, confirmed that in 2013 there were 4 who were less than 1,500 grams 1 = between 501 to 1000 grams 3 = between 1001 to 1500 grams. All 4 were delivered at the only hospital.

3. **Field Name:** 2012
   
   **Field Note:**
   NA - American Samoa does not have any facilities for high-risk deliveries and neonates. Department of Health's HIS office reported that of the total 1175 live births reported from LBJ Hospital, 6 live births were weighing less than 1,500 grams (3.3lbs).

4. **Field Name:** 2011
   
   **Field Note:**
   NA - American Samoa does not have a high risk birthing facility. The LBJ Hospital's Nursery had registered 43 births were less then 2500 grams. Three under 1500grams died (two were twins) and four lived. Of those who weighed 1500grams to 2500grams, thirty-four (including 8 who were twins) lived and two died (twins).

**Data Alerts:** None
NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

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Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014

   **Field Note:**
   Numerator is based on # of live births with 1st prenatal care in first trimester based on postpartum cards. Denominator is based on # of live births for the year.

2. **Field Name:** 2013

   **Field Note:**
   Data is based on Kotelchuck (post partum) cards.

   Based on what we have on record as of today, out of 1,161 women gave birth in 2013, completed information to determine this PM is based on 377 completed info on spreadsheet and out of the 377(denominator), 88 of those 377 received PNC beginning in the 1st trimester which is 23.3%. Though the #s are different then from the previous years, it does reflect an accurate picture of women receiving prenatal care in the 1st trimester. There is still a vast number of women coming in the 2nd or 3rd trimester or not even until they are in labor. There has been continuous awareness and education for mothers that were conducted in the community; however, #s are still small as there are factors that affects the mothers coming in for prenatal care earlier is either they are in denial they are pregnant, fear of knowing and also poor customer service.

   There is so much that needs to be done; however, MCH is working to hire a prenatal service coordinator that can coordinate ways that can bring women in early for their prenatal care instead of waiting until they’re in the 2nd or 3rd trimester. This person will assist and work with MCH coordinator in implementing new ideas to draw women early in to the clinic for their prenatal visits. Hope that there will be more funds for prenatal care services.

3. **Field Name:** 2011

   **Field Note:**
   Data Source: The denominator is a total number of postpartum and newborn cards collected by MCH staff.
Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)
State: American Samoa

SPM 1 - Percent of 15 month old children with completed immunizations.

<table>
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<tr>
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Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2014
   **Field Note:**
   Awaiting confirmed #s from Immunization program as we have not received in time of report.

2. **Field Name:** 2013
   **Field Note:**
   Data was collected from Immunization Program database known as the WEBIZ. This is considered to be the most accurate report. There has been a big drop in this area as one of the most densely populate area that serves children and provide immunizations have not input data into the Immunization WEBIZ database. This is a factor that the # has dropped. Immunization program staff are working closely with Director of Nursing and MCH staff in a solution in capturing and inputting the data into the system. However, because clinic is managed by a senior nursing staff that is not opened to change, it has been a challenge to have data being input in to the system. There should be a change in the future report as MCH and immunization program are currently having staff stationed to input data into the system and also there is a current change in staff for the WBC.

**Data Alerts:** None
## SPM 2 - Percent of pregnant women who receive adequate prenatal care based on the Kotelchuck Index.

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</table>

### Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2013
Field Note:
Data collected from post partum cards. It shows there is still a great need for education and awareness to pregnant women.

Denominator has been changed based on data available on hand due to relocation of staff and computer that was used for data input. Though 1161 pregnant women, denominator is based on excel with completed info from cards and out of the 377 women, 75 of them were identified to have received adequate prenatal care services. Though this shows a big drop as well in adequate prenatal services, it still portrays a clear picture that women are still not receiving adequate prenatal care services. If women are captured early in their pregnancy or in their 1st trimester, they are still not keeping up with their visits and follow up after their first visit as it is because of certain factors such as poor customer service where women are actually scolded by nursing staff when they come in for prenatal care services and also a lot of times, there has been a shortage of prenatal care providers. Because in the samoan culture, scolding and criticizing people is a common thing, and because the nurses serving in prenatal care are also old time nurses, they utilize their way of providing services from the past to provide services to the newer generation. Recommendations have been given to the Director of Nursing in regards to more training on customer service to the older nurses or hire new nurses that can relate to the now generation. Because of these factors with culture, it influences and impact our women coming in for their follow ups and the outcome is, they are not getting adequate prenatal care but inadequate prenatal care. MCH is working along with MIECHV program in ways that prenatal care services can be encouraged to pregnant women and maybe have the MIECVH support staff come along during the visits so that pregnant woman doesn't feel intimidated by nurse. Also MCH is about to hire a prenatal care service coordinator that can create ways that will encourage pregnant women to take advantage of their prenatal visits.

the other major reason that women are not get adequate prenatal care is because once a pregnant woman comes in after the 1st trimester, they are not eligible for the free services offers in the community health centers and the LBJ hospital. For this reason, it causes pregnant women not to come in at all as they will have to find funds to pay for their visits.

MCH coordinator and prenatal service coordinator will discuss with Community health centers how the 2nd and 3rd trimester pregnant women can benefit like the 1st trimester women so that they can take advantage of prenatal care visits.

2. Field Name: 2012
Field Note:
A total number of 944 Postpartum cards were utilized for the Kotelchuck Index because of complete records. A total of 125 women had intermediate prenatal care services and a total number of 483 number of women were considered to have received inadequate prenatal care services.

3. Field Name: 2011
Field Note:
A total number of 1240 postpartum cards were recorded by MCH.

Data Alerts: None
SPM 3 - Percent of 1 year old children attending well baby clinics who receive a package of oral hygiene services (caregiver education, fluoride varnishes, 1 toothbrush/washcloth, sticker)

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Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2013

   **Field Note:**
   This data was collected by the MCH Dental Outreach Team from all Well Baby Clinics including Leone, Amouli, Tafuna and the main WIC headwater.

   MCH Dental outreach team has been working to cover more children this year than the previous year and have shown more children being served.

2. **Field Name:** 2012

   **Field Note:**
   This data was collected by the MCH Dental Outreach Team from all Well Baby Clinics. Policies and Procedures have been approved by the Medical Director, Dr. Tufa. Its only a matter of ordering supplies, carrying out in-service trainings to WBC staff, and actual implementation. Timeframe for initiation is August 30, 2013, and data collected will be reported to the Nursing Director on a quarterly basis.

**Data Alerts:** None
SPM 4 - Percent of 2-5 year old children in well baby clinics not receiving WIC who have a BMI equal to or greater than 85%.

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Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2013

   **Field Note:**
   Data collected from Tafuna WBC.
   Denominator is based on # of children from 2 to 5 yrs and 96 of them reporting not receiving WIC but had a BMI = & > 85%.
   We are utilizing data from Tafuna WBC as we feel it portrays an accurate picture of where Children in WBC not receiving WIC but have a BMI = & > 85%.

   The decrease in % is due to the reason that a lot of these 2 to 5 year olds their BMI were not calculated at all as the clinics had broken scales and awaiting new scales which took a long time to get one. There were times also that the CNAs at the clinics were not getting the height but only getting the weight or vice versa which contributed to no BMI results.

   MCH and Nursing division have worked to do refresher trainings for CNAs and proper way of weighing children as a lot of times in accurate way of weighing a child can lead to a wrong BMI. There is also a challenge of equipment being broken more often and equipment being shared with other clinics due to shortage of equipment.

   MCH hope to be able to fund some equipment such as weighing scale to assist with getting BMI of our 2 to 5 year old children in the future.

   **Data Alerts:** None
<table>
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<tr>
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</table>

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2013

   **Field Note:**
   Data is received from Tafuna Health Center WBC - MCH staff has been conducting Hgb screening when there is enough supplies to do so.

   MCH is looking in to available funds to provide supplies in order to capture all children for Hgb screening.

   Denominator is based on TFHC's population of 1yr old as previous data collected from TFHC most likely was duplicated #s instead of unduplicated. #s are based on logbook.

   Numerator is # of children who had a Hgb screening and it was depending on supplies if a child comes in that there is enough supplies to conduct a Hgb, that 1 yr old will get it, if not, then nothing was done.

   Though have been a shortage of supplies, the WBC have continued to find supplies in order to conduct a Hgb check for 1 year old. There has been a increase in the # of children receiving Hgb screening this year. However, we would like to see a greater increase this coming year.

   **Data Alerts:** None
SPM 6 - Percent of CSHCN who have annual assessments completed.

<table>
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<tr>
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Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2013
   
   **Field Note:**
   Data is based on work that was conducted by OT aides and CSN provider with the Dental School Outreach Dentist. According to report submitted: 98 annual assessments were completed as their physical assessments were mostly conducted in the schools.

   Denominator is based on # of clients referred to CSN program = 153.

   MCH program requests for more fund to hire a licensed OT or PT to provide services to our CYSCHN and where they are not being neglected and also a CYSHCN coordinator to coordinate activities for our children and youth with special needs.

   Because 153 is small number, MCH program hopes to conduct all annual assessments for the total clients that have been referred to MCH in the future.

2. **Field Name:** 2012
   
   **Field Note:**
   This data is based on the 2012 annual report from the Children with Special Health Care Team.

3. **Field Name:** 2011
   
   **Field Note:**
   This data is an estimate of CSHCN children who have an annual assessment done by the CSHCN team. Once data is confirmed, it will be finalized.

**Data Alerts:** None
SPM 7 - Number of youth and families who participate in BodyWorks class during the project year.

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Field Level Notes for Form 10d SPMs:

1. Field Name: 2013

Field Note:
This is based on health educators data collected for zumba sessions conducted at the health centers and the DOH by MCH health educators. Based on the # of employees in DOH of 288, only about 120 youths and families come out to support such wellness activity. Numerator is the number of women, youths and families taking advantage of wellness activity.

Body works class was not offered this year but Zumba wellness was since implementation of wellness policy in the DOH.

MCH will most likely change SPM#7 to rephrase it as Number of women and families who participated in Wellness activity (1hr) during project year for next year.

Data Alerts: None
Form 11
Other State Data
State: American Samoa

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.
State Action Plan Table
State: American Samoa

Please click the link below to download a PDF of the State Action Plan Table.

State Action Plan Table