

**Maternal and Child
Health Services Title V
Block Grant**

American Samoa

**FY 2020 Application/
FY 2018 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal



LOLO M. MOLIGA
Governor

LEMANU P. MAUGA
Lieutenant Governor

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DEPARTMENT OF PUBLIC HEALTH

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Public Health
Prevent. Promote. Protect.
American Samoa
Department of Health

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Deputy Director

JULY 9, 2019

Michelle H. Lawler, M.S., R.D., ACSW, Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18N33
Rockville, MD 20857

Dear Mrs. Lawler,

With this letter of transmittal, I am pleased to submit American Samoa's application for the Maternal and Child Health (MCH) Services Block Grant Federal Fiscal Year 2020. The FY 2018 Block Grant Annual Report and the FY2020 Title V Block Grant application has been submitted online via the HRSA Electronic Handbooks (EHBs) Title V Information System as required.

The American Samoa Maternal and Child Health Program stays committed to improving the health and wellbeing of women and children, including children with special health needs, and their families.

We are forever thankful for your continuous support and being creative in addressing our unique challenges and priority needs in the Pacific region. Please contact Dr. Anaise Uso via email at anaise@doh.as or call (684) 633-4008 should you have any questions.

Very Respectfully,

Motusa Tuileama Nua,
Director, Department of Health

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Program Overview

American Samoa is a territory of the United States of America, classified more specifically as an unincorporated, unorganized territory of the United States. Simply, American Samoa is afforded diplomatic and military protection from the US, but not all of the provisions of the US Constitution apply to its people. An example would be American Samoa citizens classified as US Nationals, not US citizens. All American Samoa born citizens are considered US Nationals. American Samoa includes five volcanic islands (Tutuila, Aunu'u, and the Manu'a islands of Ofu, Olosega, and Ta'u) and two coral atolls (Rose and Swains atolls). This US affiliated group of islands shares maritime borders with another set of Samoan Islands (9 altogether) that operate under an independent type of government. Despite this difference, all of these Samoan island groups share the same ancestor lineage, language, and culture.



The geographical location of some of these islands compared to the main Tutuila island can, at times, cause difficulty in accessing care. For example, people residing in the Manu'a Islands and Aunu'u will have to travel by air or by boat to the mainland Tutuila to receive comprehensive care such as an x-ray, refill prescriptions, or surgical needs. Although there are healthcare centers in the Manu'a Islands, the available services are but a few.

The total population of American Samoa is 55,519 (2010 census). Over half (53%) of the population of American Samoa is less than 20 years of age. According to the 2010 census, there were 28,170 males (50.7%) and 27,349 (49.3%) females. A majority of the population resides in the Western District with 31,329 residents (56.4%). This is followed by the Eastern district with 23,030 residents (41.5%), then the Manu'a district with 1,143 residents (2.1%). The total fertility rate in American Samoa is 2.7 children born/woman. However, the population is decreasing due to out migration. About half of the people living in American Samoa were born there, with most immigrants coming from the Independent States of Samoa in search for jobs and to visit relatives. Many of them remain and establish families. There is no welfare system in American Samoa, however, a federally funded food stamp program is available for the elderly and children with special needs, as well as the Women, Infants, Children (WIC) Nutrition Program.

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

The recession may have extended into the following year, if not for a devastating storm that impacted much of American Samoa in February of 2018. By some estimates, Tropical Storm Gita caused as much as \$125 million in direct and indirect damages across the

territory. At least 50% of all individuals in the territory were faced with significant damage to real and/or personal property during the storm. Food, water, and other basic necessities were in high demand throughout the days and weeks that followed. During that time, automated teller machines were persistently low on cash supplies as the people of the territory scrambled to draw enough to cover immediate repair and replacement costs. Additionally, international relief agencies distributed pre-loaded gift cards to families and individuals that were most affected by the storm. Disaster relief funding is expected to contribute to consumer and government spending in 2018. Once the immediate effects of the tropical storm have diminished, so will many of the economic stimulus benefits.

Non-communicable diseases (NCDs) continue to be the leading causes of morbidity and mortality for adults in American Samoa, similar to other US Affiliated Pacific Islands Jurisdictions. Recently released was the American Samoa 2018 Adult Hybrid Survey, a population-based household survey, combined NCD and associated risk factor indicators and substance use conducted between 2017-2018. From 2004 to 2018, cigarette smoking and alcohol consumption prevalence decreased, although binge drinking prevalence and remained about the same. Overweight/obesity (94.7%) and diabetes (45.4%) prevalence remains high in American Samoa.

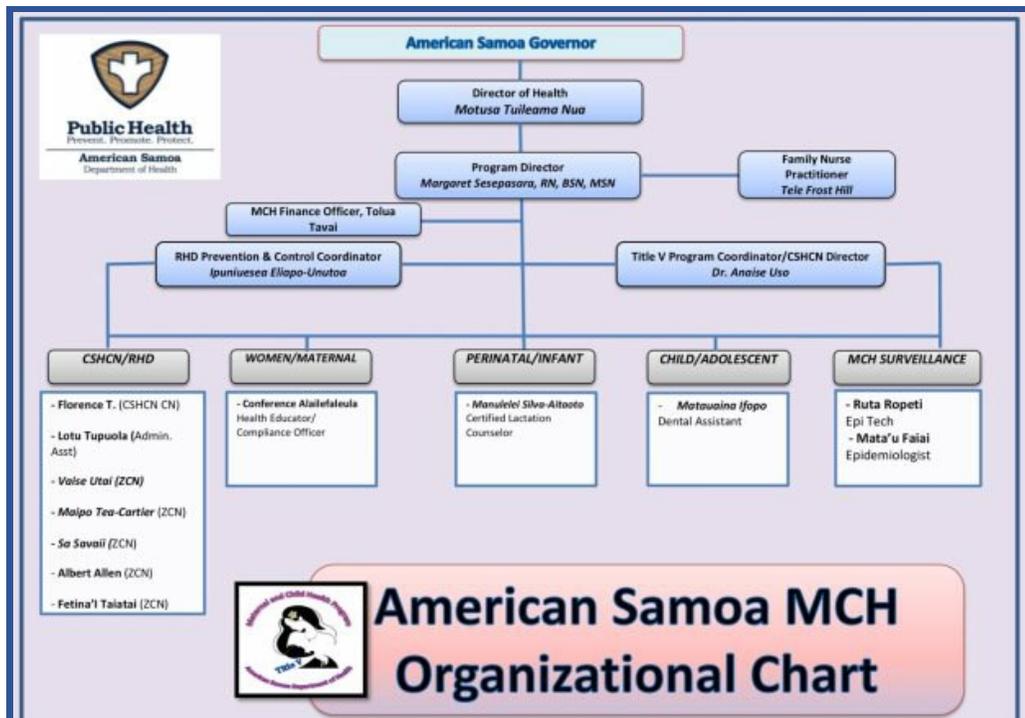
The healthcare system in American Samoa is comprised of one local hospital; one federally funded community health center and 5 satellite health clinics throughout the island of Tutuila and Manu'a, as well as an outpatient veteran's clinic. There are a few private clinics ranging from optometry to general health available for public access. There is no health insurance program for the whole of the territory, except for those in the armed forces and some private companies. Most people will have pay out of pocket for healthcare; however, most people are unable to afford healthcare costs, so these folks seek health services only on necessary conditions.

There are limitations on specialty care availability on the island. Most healthcare providers are general practitioners with limited training or exposure in special areas of medicine. If specialty care is available, they are likely contracted for a specific brief period of time. Many of the students who leave the island to seek further education to become a healthcare provider don't return because the earnings are not sufficient. Due to shortages of physicians, nurses, and other healthcare professionals, at times clinics are left with only an administrator or an assistant and the public is referred to clinics that may be of further distance where a provider is available.

The local health department envisions Healthy FAMILIES, Healthy COMMUNITIES, and Healthy AMERICAN SAMOA. Its mission statement states "To effectively and efficiently deploy available public health, human and material resources: to PROMOTE physical and mental health; to PREVENT disease, injury, and disability; and to PROTECT individual rights to access quality and affordable health care services for all residents of American Samoa". In support of women and children, the local health department partners with the federal government to ensure healthcare services for the MCH population is continually addressed and improved.

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

Figure 1: American Samoa MCH Program Organizational Chart:



Majority of the MCH direct services occur in the community health centers (Prenatal and Well Child Clinics). With Title V funds, nurse practitioners, dental assistant, health educators and special needs client navigators, are fully funded by the MCH Program to provide services at these centers. The local health agency influences and supports Title V priorities by integrating existing programs to work with each other, creating bigger outcomes and more successful results. An example would be having a family access both well child and prenatal services at the community health center. These services are supported by not only MCH, but also with Tobacco/Diabetes Program, Breast & Cervical Cancer Program, NCD program and of course CHC overall. Each program targeting their own agenda and task while the family is able to access comprehensive care, a win-win situation for everyone involved.

There are only a handful of pediatric trained providers on the island. The health care centers employ 3 pediatric trained physicians, however, only one provides services directly for children through the well child clinics, the other two are assigned administrative roles and serve the general public. So, all children, with and without special needs are primarily cared for at the local hospital, which is Supporting services such as behavioral, mental, and social aspects are offered through the Department of Human and Social Services. Non-profit organizations also play a significant role in the care of children in the territory, providing necessities and support through groups and pertinent information.

Specialty care is dependent upon traveling consultants and recruitment. When specialty care is not available, children and their families are often recommended for off-island referral. Air travel is covered by the local hospital; however, all other associated costs are imposed on the family to cover. Some families never return home due to continuous need of care and lack of available resources on the island.

According to the Medicaid Title XIX program, all children and pregnant mothers are eligible for Medicaid coverage. However, women, children including children with special needs are still required to pay out of pocket for their medical expenses, particularly if services are accessed through the local hospital. This is a complication that the Title V and Title XIX are currently working on to resolve, as there are incongruities in the law that needs modifications. The health department overall provides oversight and guidance so that these efforts are integrated into the system of care, which will expect to increase access for all pregnant women and children in American Samoa.

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

In the table below, it lists all the domain related priority needs and American Samoa's selection is based on the 2015 Needs Assessment listed in Table 1 below.

Table 1: American Samoa MCH Title V Priority Needs

Population Domain	AS MCH Priority Needs	New (N), Revised (R) or Continued (C) Priority Need for this five-year reporting period		
		N	R	C
Women	1. Promote preventive medical visits for women ages 21 – 44. NPM1			X
	2. Reduce pregnant women diagnosed with Zika viral infection. SPM1			X
Perinatal and infants	3. Promote breastfeeding for infants 0-6 months. NPM4			X
Children	4. Promote evidence based developmental screenings for children ages 0 – 3 years. NPM6			X
	5. Promote Oral Health for children ages 0-3 years. SPM2			X
	6. Promote immunization coverage for children ages 3. SPM3			X
	7. Reduce Acute Rheumatic Fever and Rheumatic Heart Disease. SPM4			X
Adolescent	8. Promote preventive medical services for adolescents ages 12-17. NPM10			X
CYSHCN	9. Improve system of care for CYSHCN. NPM11			X
	10. Promote care coordination services for children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV. SPM5			X

American Samoa MCH Title V's five-year State Action Plan was developed to assist in aligning program strategies and activities with identified needs and performance measures. Each year the American Samoa Title V updates on progress toward the identified measures and implement changes to strategies and activities as appropriate.

Together with local funds and other additional federal funds, the Title V MCH block grant is used to address American Samoa's MCH priority needs, improve performance related to targeted MCH outcomes, and expand systems of care for the MCH and CSHCN populations. American Samoa's Title V Leadership Team—which includes the Title V MCH director, Title V CSHCN director, and key Title V administrative staff—meets on a regular basis to discuss all aspects of Title V, including the budget and how federal and non-federal funds are used to address the state's MCH needs.

The key accomplishments for FY 2018 and plans for FY 2020 are summarized below.

DOMAIN: WOMEN'S/MATERNAL HEALTH

Promote preventive medical visits.

Accomplishments: Title V is a key partner in driving the planning and implementation of women's health services at the department of health and community health centers including NCD screening and management; depression screening and referral; breast and cervical screening; family planning measures; dental screening and management; depression and tobacco screening, cessation counseling and referrals.

Challenges: Acquiring timely data to monitor project benchmarks and complete evaluation has been challenging.

Plans: Collaborate with Well Child Clinics to send postpartum mothers for check-up and family planning. Will also focus on public awareness and messaging to promote healthy behaviors including preventive women's health visits and reproductive life planning.

DOMAIN: PERINATAL/INFANT HEALTH

Promote breastfeeding.

Accomplishments: MCH Title V staff continues to partner with MEICHV, WIC, OBGYN, LBJ Nursery and Community Health Centers to promote breastfeeding initiatives including celebrating BF Week in August, annually. Home visitors have more than 70% success rate in achieving an 80% successful rate in clients enrolled in MEICHV. WIC continues to be a key partner due to its successful Breastfeeding Peer Counselor Project.

Challenges: Territorial Breastfeeding Coalition is inactive and needs to reconvene, plan and implement a Strategic BF Plan.

Plans: Promote and support breastfeeding in government and non-governmental workplaces such as supporting at least 2 hours break for breastfeeding. Conduct a BF workgroup to draft and approve the American Samoa Territorial Breastfeeding Plan.

DOMAIN: CHILD HEALTH

Promote evidence based developmental screenings for children ages 0 – 3 years.

Preventive Dental services

Complete age appropriate vaccinations

Prevent Rheumatic Fever and Rheumatic Heart Disease

Accomplishments: Completed training of Client Navigators to boost developmental screenings. This current year, MCH program finally had a dental assistance on board who will boost preventive dental screenings, fluoride varnish and referrals for treatment at Tafuna and Fagaalu Well Baby Clinics. Vaccination coverage have improved slightly. Another accomplishment was identifying all RHD diagnosed patients in the territory to build an RHD registry with the assistance of a CDC Epi Aid.

Challenges: Key challenges include promoting greater collaboration across the service system to strengthen the impact and sustainability of prevention programs, and identifying effective/affordable evaluation measures for population-based prevention activities/campaigns.

Plans: Continue to promote early developmental screenings and referrals for early interventions, promote oral health, immunization coverage and implementing a robust RHD program that includes free secondary prophylaxis to prevent further damages to hearts of RHD clients.

DOMAIN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Improve systems of care for CSHCN.

Accomplishments: The CYSHCN program staff was able to provide care coordination to majority of clients that were recruited into the program. These clients received components of a well-functioning system, to include family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition.

Challenges: Establishing partnerships with adult health care agencies and providers to promote transition planning is a challenge given shortages of adult health care providers, especially for CSHCN. Developing methods to measure the effectiveness of education/outreach activities is also an ongoing process.

Plans: Development of education and assessment materials will be completed, as well as the data monitoring system. Education and public awareness on transition to adult health care will continue. CYSHNS will also partner with the Title V Adolescent Health Program to increase outreach to all adolescents, with and without special health care needs.

Five Year Needs Assessment

The Title V needs assessment plan is completed, and implementation has begun in FY 2019 including both primary and secondary data collection with technical assistance from the University of Hawaii's Office of Public Health Studies. MCH Title V has formed a needs assessment collaborative to utilize resources from several ASDOH programs including Title V, MIECHV, EI, the Community Health Centers, and other external key stakeholders. New five-year priorities will be identified by October 2019 and plan strategies, activities, and strategy measures will be selected by May 2020.

III.A.2. How Federal Title V Funds Support State MCH Efforts

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

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

III.A.3. MCH Success Story

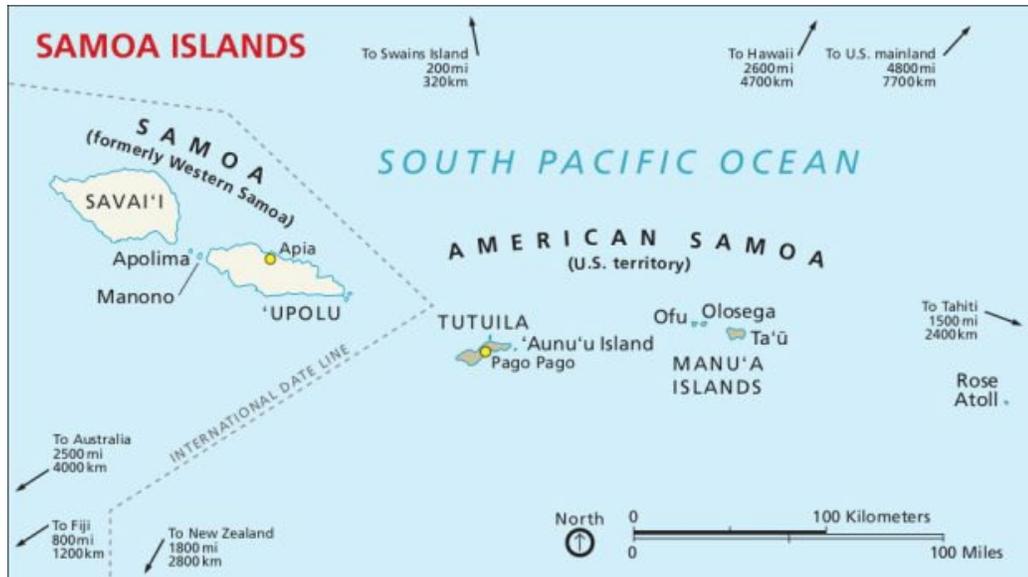
For the year 2018, success of the RHD control & prevention work:

- American Samoa Community Health Centers were approved for the 340B Discount The RHD program was able to put in a request through CHC to purchase bicillin injections at a discount. The approval allowed the RHD program to purchase a box of 10 injections for only 20 cents apiece. The original cost of this box through the hospital is earmarked at \$160 dollars per box. This has allowed the RHD program and the FQHC's to incorporate a plan to provide bicillin to the public – for free.
- Two schools offered donations as part of the student's community projects, to support RHD efforts. Altogether, a donation of \$10,000 was donated towards bicillin and specialty care.
- Training for echo technicians was implemented in early 2018, for 7 local health workers from both the LBJ Hospital and DOH.
- Images that are captured from this screening clinic are uploaded to a cloud-based HIPAA certified system, which tags volunteer Cardiologists to examine and diagnose each case.

There is much work to be done, however, in reviewing the impact that has happened so far for the RHD population, MCH Title V should be recognized as one of the leading support for all these successes.

III.B. Overview of the State

Overview of State



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

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

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

Population: According to the US Census International Program, an estimated population by for the year 2018 for

American Samoa was projected to be at 50,826. This is a decrease from the previous estimated census in the previous years. This can be verified also by the decrease numbers of live births as registered in the vital statistics bureau for the territory.

American Samoa is divided into four geo-political districts: Western District, Eastern District, Manu`a District, and Swains Island District. The population distribution for these districts show that there are 31, 329 residents (56.4%) in the Western District, 23, 030 residents (41.5%) in the Eastern District, 1,143 in the Manu`a District and 17 residents in the Swains Island District (2.1%). As of December 31, 2018, total gender-based population estimates were at 25,412 males and 25,414 females. In assessing the population distribution by age, American Samoa has a young population of 28 percent (15,037) consisting of those less than 15 years of age. For the total population, 66 percent (33,615) of population falls between 15-64 years old, with only 6 percent (3,174) of ages 65+.

Ethnicity: Of the population, 91.6 percent reported as Pacific Islander are native Samoans, 2.8 percent are Asian, 1.1 percent is Caucasian, 4.2 percent are mixed, and 0.3 percent is of other origin. Although majority of the population is consistent of native Samoans, more than two-fifths of the population were born outside of the territory, largely in the neighboring independent Samoa Island, with smaller proportions from the United States, other Pacific Islands, and Asia Countries.

Language: Most people are bilingual and can speak English and Samoan fluently. Samoan, a language closely related to Hawaiian and other Polynesian languages, is spoken natively by 9 percent of the people as well as the co-official language of the territory. While 80 percent speak English and Samoan, 2.4 percent speak Tongan, 2 percent speak Asian languages, and 2 percent speak other Pacific Islander languages. Tokelauan language is also spoken in Swains Island. Literacy is calculated at 97 percent.

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

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

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

According to a report published by the American Samoa Department of Commerce in 2008 called *American Samoa's Economic Future and the Cannery Industry*, the reduction in Tuna cannery operations can impose a

strong possibility that economic distress would remain very high in American Samoa for a long time in the form of very high rates of unemployment, business closures or cutbacks and precipitous declines in local revenues. These conditions could have a variety of adverse effects on the community that includes: (1) Increased family and social stress that often translates into criminal behavior including domestic violence. (2) Declining economic opportunities for youth entering the workforce. (3) Declining local revenues for health, education and general public welfare, as well as investments in capital projects and maintenance. (4) Rising economic dependence on the federal government. (5) Fewer resources to preserve Samoan culture and the physical environment. These conditions have become a reality for the entire community, becoming a dreadful effect on the economy, particularly for low-income families who were solely reliant on cannery work.

As noted, American Samoa had about 11,034 housing units in 2015. Of the types of tenure, houses owned free and clear were 74.7 percent, so about 3 in every 4 units. The others were owned with a mortgage (10.2 percent), rented for cash rent (11.1 percent), and occupied without payment of cash rent (4.0 percent). Many families in single-family units had a business on their property – 7.2 percent of all units. Houses continue to get larger, with the median number of rooms increasing to 5.4 with an average of 3.4 bedrooms. Metal roofs continue to predominate (at about 4 in every 5 units), with smaller numbers having poured concrete or wood. Only about 1 in every 4 housing units have access to hot and cold water. But more and more American Samoa families are able to afford appliances. In 2015, these included a Stove (81.2 percent of all housing units), Microwave (58.3 percent), Refrigerator (92.2 percent), Freezer (45.2 percent), Air conditioner (40.1 percent), Television (86.3 percent), and Computer (33.5 percent). However, only about 3 in every 5 units had a vehicle at home.

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

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

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

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

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

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

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

The American Samoa Medical Center Authority (ASMCA), the only hospital in American Samoa, provides all acute medical services and includes outpatient clinics as well as inpatient hospital care. The ASMCA provides outpatient care at the Emergency Room, Primary Care Clinic, Pediatric Clinic, Obstetrics and Gynecology Clinic, Surgical Clinic, Medical Clinic, Ear Nose Throat Clinic, Dialysis Clinic, Psychiatry Clinic, Dental Clinic, and the Eye Clinic. The inpatient services include 125 patient beds in six wards: Labor and Delivery, Nursery, Maternity, Internal Medicine, Surgical, Intensive Care, and Psychiatry.

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

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

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

The Department of Health is also responsible for infectious and chronic disease surveillance and prevention, community nursing services, environmental health, immunization, Public Health emergency preparedness, comprehensive cancer control, HIV and STD screening, early intervention, newborn hearing, as well as MCH services that includes the Maternal Infant Early Childhood Home-visiting (MIECHV) Program.

A Medicaid Program exists in American Samoa, operating directly under the Governor's office. American Samoa's Medicaid program was established in 1983. It is a 100% fee-for-service delivery system with one hospital servicing the territory. There are no deductibles or co-payments under the American Samoa Medicaid program, however there are some fees charged by the hospital located in American Samoa. Through Section 1108 of the Social Security Act (SSA), each territory is provided base funding to serve their Medicaid populations. For the period of July 1, 2011 through September 30, 2019, Section 2005 of the Affordable Care Act provided an additional \$181,307,628 in Medicaid funding to American Samoa. These monies have allowed the Medicaid program to support an off-island referral process for cases that cannot be addressed in American Samoa. These cases are directly referred to New Zealand to further care under the sponsorship of the Medicaid program. Some of these cases include children who require heart valve replacement surgeries due to complications of Rheumatic Heart Disease and babies born with congenital defects.

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

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

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

DHSS and DOH often collaborate in efforts that combine the social and health aspect of the community, respectively. The MCH Title V program partners with DHSS annually for breastfeeding, nutrition, behavioral health, child care, oral health, and surveillance efforts. DHSS primarily conducts the SBIRT (Screening, Brief Intervention, and Referral to Treatment) tool to identify, reduce, and prevent the use, abuse, and dependence on alcohol and illicit drugs.

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

Care and Dental operated by an Orthodontist.

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

- [Grace Home Care Services](#) – providing homecare services to the people with disabilities and the elderly
- [Hope House](#) - the only nursing home-type of setting on island, housing the elderly and children with severe disabilities
- [Alliance for Families](#) – providing support services for victims of domestic abuse and violence, shelter for families in difficult situations, and workshops/educational sessions on community-based services
- [Intersections](#) –a non-profit, faith-based organization that provides peer-to-peer educational session on sex education throughout the school systems to adolescents and youth.

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

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

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

III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

The American Samoa Maternal Child Health Program will utilize the AMCHP MCH Needs Assessment Toolkit specifically, the nine step, MCH Needs Assessment Conceptual Framework to guide and inform the 5-year MCH Needs Assessment process. For step 1, *engaging stakeholders*, the AS MCH is in the process of recruiting internal and external stakeholders who are relevant to the MCH population domains (Women/Maternal Health, Perinatal/Infant Health, Child Health, Children with Special Healthcare Needs and Adolescent Health). The following are stakeholders we plan to recruit due to the relevant MCH population domains they serve: LBJ Medical Center's Nursery Division and Labor/Delivery Division (Women/Maternal Health, Perinatal/Infant Health), Women Infants and Children (WIC) Program (Women/Maternal Health, Perinatal/Infant Health, Child Health), AS Maternal Infant Early Childhood Home Visiting (MIECHV) Program (Women/Maternal Health, Perinatal/Infant Health, Child Health), Helping Hands Part C Early Intervention Program, and the Helping Babies Hear Program (both for Children with Special Healthcare Needs), AS DOH Immunization Program (Perinatal/Infant Health, Child Health, Children with Special Healthcare Needs and Adolescent Health), and the Department of Education Early Childhood Education (ECE) Program (Child Health) , the Special Education (SPED) Program (Children with Special Healthcare Needs), Elementary Division and Secondary Division (Adolescent Health).

The second step of the MCH Needs Assessment Conceptual Framework is to *assess or identify outcomes*. Once we finalize a list of MCH internal and external stakeholders, we will schedule monthly meetings with stakeholders throughout the year (September 2019- September 2020). The third step of the conceptual framework is to *examine the strengths and capacity of current programs and services* (direct, enabling, and public health) for each MCH population domains. The evaluation of programs and services will be a collaborative effort of MCH and stakeholders as a whole during the monthly meetings scheduled. After the evaluation of programs and services available to each MCH population domain, MCH and the respective stakeholders relevant to an MCH population domain will *select priorities to improve outcomes*, which is step 4 for the MCH Needs Assessment conceptual framework. At least 1 or 2 priorities will be assigned according to each of the 5 MCH population domain, with a total of 7-10 priorities identified for MCH population domains.

Once priorities for each MCH population domain is identified by MCH and its stakeholders, they will identify outcome and performance objectives: National outcome and performance measures (NOMs and NPMs), state outcome and performance measures (SOMs and SPMs), and evidence based informed strategy measures (ESMs) for each of the 7-10 MCH priorities, which is step 5 of the conceptual framework. The performance objectives will be set with the 5-year period of the next needs assessment in mind. Therefore, step 6 of the MCH conceptual framework is the *development of a Five Year MCH Territory Action Plan by MCH and its stakeholders* with the 7-10 MCH priority needs of each MCH population domains, and key strategies (both political and at the program level) to meet the needs identified. With the Five Year MCH Territory Action Plan in place, MCH will work with its stakeholders to *seek and allocate resources* or step 7 of the conceptual framework. Specifically, allocate adequate funds to perform program activities to meet priority needs identified, and formulate continuous and lasting partnerships with needs assessment stakeholders. Furthermore, step 8 of the conceptual framework is to *monitor the progress of performance objectives* (NOMs, NPMs, SOMs, SPMs and ESMs) through quantitative data collection (prevalence, rates etc.) and qualitative data collection (key informant interviews, focus groups etc.). When the 5-Year MCH Needs Assessment is completed, MCH will *report back to its stakeholders* as step 9 of the MCH Needs Assessment Conceptual Framework. MCH will hold several meetings to disseminate the findings of the MCH Needs Assessment to its stakeholders involved in the entire MCH Needs Assessment process. Once the findings

are disseminated, MCH will begin the strategic thinking process of the MCH Needs Assessment Findings Dissemination. Through strategic planning, MCH will collaborate with its stakeholders to come up with recommendations for action of the 7 to 10 priority needs of MCH and its population domains.

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Table 1: Revised AS MCH Priority Needs in 2018.

Population Domain	AS MCH Priority Needs	NEW (N), REVISED (R) OR CONTINUED (C) PRIORITY NEED FOR THIS FIVE-YEAR REPORTING PERIOD		
		N	R	C
Women	1. Promote preventive medical visits for women ages 21 – 44. NPM1			X
	2. Reduce pregnant women diagnosed with Zika viral infection. SPM1			X
Perinatal and infants	3. Promote breastfeeding for infants 0-6 months. NPM4			X
Children	4. Promote evidence based developmental screenings for children ages 0 – 3 years. NPM6			X
	5. Promote Oral Health for children ages 0-3 years. SPM2		X	
	6. Promote immunization coverage for children ages 3. SPM3			X
	7. Reduce Acute Rheumatic Fever and Rheumatic Heart Disease. SPM4			X
Adolescent	8. Promote preventive medical services for adolescents ages 12-17. NPM10		X	
CYSHCN	9. Improve system of care for CYSHCN. NPM11			X
	10. Promote care coordination services for children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV. SPM5	X		

The American Samoa MCH Title V program strategically used unique opportunities in the past year to gather and update necessary information to identify Current Needs for its population.

Majority of the MCH work conducted throughout the year 2017 focused heavily on the territorial Zika Response efforts and Rheumatic Heart Disease prevention and control. Throughout the year, MCH was one of the leading programs involved in numerous meetings with stakeholders and community members to discuss issues pertaining to these areas of concern. This afforded MCH to work closely with and learn from partners at the federal level (CDC, WHO, WHF, etc.), as well as the state/local level (LBJ Hospital, Department of Human & Social Services, Department of Education, Land Grant, Am. Samoa Environmental Protection Agency, etc.). This also reinforced professional relationships with existing partners such as Early Intervention, Family Planning Program, Public Health Emergency Preparedness Program, and a variety of clinics and programs at the local hospital.

Through the Zika Response efforts in 2017, MCH was able to determine ongoing needs among maternal and children population. Pertinent specific needs such as transportation to and from clinics, care coordination (including follow up-calls for appointments), and access to specialty care (Audiology, Ophthalmology, etc.) were identified. In meeting these specific needs, mothers and children were better able to access care and comply with required health visits. Families were more open to navigators checking in monthly and developed a more stable personal relationship and trust to ensure their health

needs are met.

Weekly Unified Health Command (UHC) meetings were held since the Zika Outbreak Declaration back in 2016. Through these meetings, MCH was able to report and discuss data on identified Zika clients. From these meetings, MCH staff continued to refine areas of data collection, improve on data capacity to guide ongoing efforts for existing systems of care. Additionally, two client navigators were hired to conduct care coordination for the Zika population, which was also vital in determining ongoing needs for the MCH population.

In RHD work, community members such as legislators, health care providers, information officers, education officials and family representatives were invited to participate in team meetings to provide input through Appreciative Inquiry, an approach implemented and guided through experts from the MCH Workforce Development Center. These opportunities allowed the MCH program to expand its vision on the control and prevention of RHD among the children population, as well as closing gaps in the system of care for both children and pregnant women diagnosed with this condition.

From the Zika and RHD work, combined with efforts in other priority areas for MCH, it is clear that care coordination is a major factor in optimizing health outcomes for women and children in American Samoa. By establishing a relationship of trust and practical support, women are more proactive in accessing care for themselves and their children. This in turn increases the utilization of health centers as medical homes that are accessible and comprehensive for all families, not just clients for CYSHCN or Zika.

Program capacity has also evolved through these findings, such as strategic usage of available staff and resources, and self-reflections or program evaluations on efforts that may or may not be beneficial to improving serves the community. MCH Staff has adjusted to many different roles based on expectations from the different levels authority, which has furthered our skills in multi-faceted health activities locally and federally.

In table 1 above, revised priority needs were generated for FY19 action plan determined by various recommendations among ASDOH senior leaders and key stakeholder partners. In 2015 per the grant guidance, ASMCH was obligated to formulate some of the priority needs to ensure each domain had a NPM including cross-cutting. This year, they were deleted to ensure available resources are maximized to address top priority needs specific and unique to the territory. Some of the criteria strategically used to determine this outcome included the availability of (1) resources, (2) programs to address these priority needs and (3) annual data for reporting. Priorities deleted include “reduce bullying among adolescents”, “reduce smoking in pregnant women”, and “reduce childhood obesity.” Department of Education are now providing anti-bullying initiatives and promoting childhood obesity prevention in physical education classes. Tobacco Program will continue to promote smoking cessation counseling to pregnant women.

The new priority need added is to promote care coordination for families for congenital Zika babies or infants born to mothers who were diagnosed (laboratory confirmed) with Zika during their pregnancy up to age three years. Revised priority needs include promoting Oral health for children ages zero to three has been moved from cross-cutting domain (NPM 13) to State Performance Measure 2, which is more age specific. The other revision is adding on specific age groups to the NPM 10 (preventive medical visits for adolescent ages 12 – 17) and SPM 3, promoting immunization coverage for children ages 3.

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Domain	Priority	Strategy
Women/Maternal Health	1. Promote Well Women Visits	Promote activities, which support reproductive life planning and healthy birth outcomes by increasing wellness check-up.
Perinatal/Infant Health	2. Reduce Infant Mortality through Breastfeeding	Promote activities, which support breastfeeding initiation and exclusivity.
	3. Reduce Smoking among Pregnant Women	Promote all activities, which support prevention and smoking cessation for pregnant women.
	4. Reduce Zika infection during pregnancy	Promote activities, which support prevention of Zika infection during pregnancy.
Child Health	5. Promote Developmental Screenings and Services	Promote the use of evidence-based developmental screenings for all children ages 0-5
	6. Reduce Childhood Obesity	Promote activities which support Physical Activities
	7. Reduce Rheumatic Fever and Rheumatic Heart Disease	Promote activities which support the prevention of RF and RHD
	8. Promote Immunization Coverage Rates	Promote activities, which support complete immunization by age 3.
Adolescent Health	9. Promote Adolescent Well-being	Promote activities which support adolescent well-care visits
	10. Reduce bullying	Promote activities which support bullying prevention
Children and Youth with Special Health Care Needs	11. Improve Systems of Care	Increase the number of children with special health care needs having a medical home.
Life-Course	12. Improve Oral Health	Promote activities, which support oral health in all domains.

The American Samoa MCH Title V program is taking steps to consistently assure that the Needs Assessment is an ongoing process.

A stakeholders meeting was held to discuss MCH work in 2016, where MCH population needs were discussed, and the partners at the table provided recommendations to move initiatives forward. Government agencies and private entities that relate to MCH work were part of these meetings, as well family representatives.

Partners were asked to contribute to the discussions through the different populations their work impact. Attendees were able to provide feedback that addressed various consumer perspectives that can become a hindrance to people accessing care. Service Providers and Program Managers communicated their challenges and accomplishments to continue to learn from each other and build on one another.

Since the Zika outbreak, MCH has strengthened its surveillance infrastructure to capture data that reflects on women who have tested positive or probable for Zika, as well as the babies they give birth to. The Unified Health Command meetings, which occur once a week, since the March of 2016 gather territorial partners and national agencies (CDC, HRSA, PIHOA, etc) to share data and disseminate information on Zika + or probable women and their babies before and after birth. MCH collaborates with Community Health Centers, the Newborn hearing-screening program (Helping Babies Hear), the Early Intervention Program (Helping Hands), and the Surveillance Program under Department of Health in utilizing data to improve programmatic efforts for the Zika stricken population. MCH receives input from these meetings to identify gaps and unmet needs, as well as improving on strategies and procedures.

Coaches from the Workforce Development Center conducted a site visit in May 2016 to assist in the work of improving systems of care for Children and Youth with Special Needs. The weeklong visit included a stakeholders meeting, training MCH staff on using the Systems Mapping tool, and meetings with senior leaders and related programs within the Department of Health. Several CYSHCN families were recruited for the Systems Mapping process and MCH was able to utilize this tool to further assess unmet needs and improve on care coordination skills.

MCH also attends coalition meetings that focus on similar goals such as the Non Communicable Disease Program, the Tobacco & Diabetes Program, the Preventive Health and Health Services Program, amongst several others. Through these meetings, MCH shares and receives feedbacks that influence MCH priorities.

FY 2017 Application/FY 2015 Annual Report Update

Refined Goals

1. To increase the number of women who have a preventive visit
2. To increase the proportion of infants who are breastfed and
3. To increase the percent of infants breastfed exclusively through 6 months.
4. To increase the number of children who receive a developmental screening.
5. To increase the number of children and adolescents who are physically active
6. To reduce the number of adolescents who are bullied
7. To increase the number of adolescents who have a preventive services visit.
8. To increase the number of children and youth with and without special healthcare needs who have a medical home.
9. To increase the number of pregnant women who have a dental visit
10. To increase the number of infants and children ages 1 through 17 years, who had a preventive dental visit in the last year.

The American Samoa MCH Title V program is taking steps to consistently assure that the Needs Assessment is an ongoing process.

The Title V program was accepted as part of the 4th Cohort for the Workforce Development Center Project this past year. As part of the requirements, stakeholder meetings were conducted quarterly, where MCH population needs were discussed and identified. Agencies from both the public and private sectors were part of these meetings as well as families representing these specific population groups.

Tools introduced by the Workforce Center were used in these meetings to help clarify needs, such as Systems Mapping. Parents, families, and stakeholders were asked to use the mapping tool to visually display roles, responsibilities, and challenges that were specific to their experiences and may impact the health of their family members who are mothers and children.

The Children & Youth with Special Healthcare Needs Survey results was also shared during these meetings. Stakeholders and families were able to share their input and make recommendations according to the results of this survey. The State of Hawaii LEND Program and the Workforce Development Center was able to provide in-services to the provider population in regards to the Medical Home model and the concept of care coordination for the special needs population. Providers from the Department of Health as well as the LBJ Tropical Medical Center were participants.

The AIM Project, another effort which American Samoa Title V office is currently involved with, has initiated efforts to adopt a modified version of the Bright Futures curriculum as a developmental screening tool for all infants and children throughout their preventive health visits. This is to assure early detection of developmental delays among young children therefore requiring early intervention services to improve the quality of life.

The MCH Title V team continues to collaborate efforts with other agencies in the government as well as non profit organizations in assuring data is consistently collected and analyzed thoroughly to monitor gaps in the health delivery system for this population. With the current Zika outbreak, Title V office is working closely with CDC in monitoring and assuring pregnant mothers are able to access care at first trimester, and continually follow them throughout and after pregnancy. Also, Title V leads a collaboration effort with other Department of Health programs who serve children (Immunization, MIECHV, Part C Early Intervention, Nursing) in designing a plan to monitor and follow babies born with Zika complications throughout their lifespan.

For Adolescent Health, although a slight decrease is noted for teen pregnancy this year, it is still higher than the national average. Community Health Centers report a low number of adolescents accessing services for educational, religion or military requirements, but not necessarily for ongoing preventive care. The Title V team has initiated partnership with a non-

governmental organization called Intersection Inc. which utilizes peer-to-peer approach, encouraging young people to make better decisions on issues such as abstinence, healthy relationships, and addressing risky behaviors among teenagers.

Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)

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.

Vision:	Healthy Families, Healthy Communities, Healthy American Samoa
Mission:	<i>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.</i>
Goals:	<i>To enhance the health of American Samoa women and infants across the lifespan.</i> <i>To enhance the health of American Samoa children and adolescents across the lifespan.</i> <i>To enhance the health of all American Samoa children and youth with special health care needs across the lifespan.</i>

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 actions.

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 is 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.

□

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:

DISTRICTS	Perinatal Health	School Readiness	CYSHCN
Western	16-39 yrs. old	16-39 yrs. old	20-40 yrs. old
Central II	16-39 yrs. old	16-39 yrs. old	20-40 yrs. old
Central I	16-39 yrs. old	16-39 yrs. old	20-40 yrs. old
Eastern	16-39 yrs. old	16-39 yrs. old	20-40 yrs. old
Ta’u (Interview)	Ta’u (Interview)	Ta’u (Interview)	
Ofu (Interview)	Ofu (Interview)	Ofu (Interview)	

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

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

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

II.B.2. Findings

Results on comprehensive needs assessment.

II.B.2.a. MCH Population Needs

11.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

FOCUS GROUPS: PERINATAL HEALTH	
Individual – level Factors	<ul style="list-style-type: none"> *Limited access to use of contraception *Lack of transportation *Contraception not available at the health centers *Lack of understanding in contraceptive measures *Couldn't get an appointment *Didn't realize they were pregnant *Lack of money/insurance coverage *Culture *Fear of others knowing *Too many things going on
Structural – level Factors	<ul style="list-style-type: none"> *Only one location on island at the main hospital *Lack of transportation *Lack of personnel *Lack of a Teen pregnancy clinic
KEY INFORMANT INTERVIEWS	
Priority Needs	<ul style="list-style-type: none"> *Well woman visits *Breastfeeding *Maternal Mortality *Infant Mortality *Teen Birth rates *Sexually Transmitted Infections *No services as the Manu'a Clinics (Ofu and Ta'u)
Individual – level Factors	<ul style="list-style-type: none"> *Lack of awareness on prenatal care *Lack of awareness of NCD that can affect pregnancy *Provider too familiar with client and/or too personal *No money to pay for visit
Structural – level Factors	<ul style="list-style-type: none"> *Lack of awareness to the public and community *Lack of staff *Not leveraging program *Lack of access to facilities *Contraceptive measures not available at all community health centers *Poor customer service by staff

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

FOCUS GROUPS: PERINATAL HEALTH	
Individual – level Factors	<ul style="list-style-type: none"> *Familiarity of provider with client leads to clients not to attend visits. *Lack of transportation *Lack of awareness on available services for women preconception care, perinatal, pre-natal care and post partum care. *Lack of benefits of breastfeeding, SIDs, etc.
Structural – level Factors	<ul style="list-style-type: none"> *Lack of support system *Lack of awareness
KEY INFORMANT INTERVIEWS	
Priority Needs	<ul style="list-style-type: none"> *Perinatal regionalization system *Safe Sleep *Breastfeeding education *Lack of services in Manu'a (Ta'u and Ofu)
Individual – level Factors	<ul style="list-style-type: none"> *Lack of awareness on benefits of breastfeeding *Lack of support from families and providers *Lack of services in Manu'a (Ta'u and Ofu)
Structural – level Factors	<ul style="list-style-type: none"> *Lack of access to health centers *Lack of transportation *Lack of fund to pay for services *Poor customer service

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

<p>Individual – level Factors</p>	<ul style="list-style-type: none"> *Lack of transportation *Lack of a developmental screening *Lack of knowledge about school readiness *Limited parent's understanding of nutrition
<p>Structural – level Factors</p>	<ul style="list-style-type: none"> *Lack of support system *Transportation challenges *Village immunization campaign only limited to flu shots *Lack of staff *NO New Born Screenings *Lack of Finances
<p>KEY INFORMANT INTERVIEWS</p>	
<p>Priority Needs</p>	<ul style="list-style-type: none"> *Physical Activity *Awareness *Lack of services in Manu'a (Ta'u and Ofu)
<p>Individual – level Factors</p>	<ul style="list-style-type: none"> *Lack of motivation from peers *Lack of support from families *Culture *Lack of Finances *Lack of services in Manu'a (Ta'u & Ofu)
<p>Structural – level Factors</p>	<ul style="list-style-type: none"> *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 of the public schools, 80% of all who were present in the room attest to have experienced being bullied or bullied others. Racial disparities exist 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 adolescents 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	<ul style="list-style-type: none"> *Lack of transportation *Lack of providers to serve children *Bullying *Culture’s view on sex education
Structural – level Factors	<ul style="list-style-type: none"> *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	<ul style="list-style-type: none"> *Physical Activity *Awareness *Lack of services in the remote islands of Manu’a (Ta’u & Ofu)
Individual – level Factors	<ul style="list-style-type: none"> *Lack of motivation from peers *Lack of support from families *Culture *Lack of Finances
Structural – level Factors	<ul style="list-style-type: none"> *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

FOCUS GROUPS:CYSHCN HEALTH	
Individual – level Factors	<ul style="list-style-type: none"> *Lack of knowledge about services *Poor communication between parents and providers *Lack of transportation *Families are responsible for care coordination *Concern over transition to adulthood *Lack of providers to see this population *Bullying *Culture's view on
Structural – level Factors	<ul style="list-style-type: none"> *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	<ul style="list-style-type: none"> *Physical Activity *Awareness *Lack of services in the remote islands of Manu'a (Ta'u & Ofu)
Individual – level Factors	<ul style="list-style-type: none"> *Lack of motivation from peers *Lack of support from families *Culture *Lack of Finances
Structural – level Factors	<ul style="list-style-type: none"> *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 CYSCHN 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

FOCUS GROUPS:CROSS-CUTTING/LIFE COURSE HEALTH

<p>Individual – level Factors</p>	<ul style="list-style-type: none"> *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
<p>Structural – level Factors</p>	<ul style="list-style-type: none"> *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
<p>KEY INFORMANT INTERVIEWS</p>	
<p>Priority Needs</p>	<ul style="list-style-type: none"> *Lack of knowledge in oral health of adolescents *Awareness *Lack of services in the remote islands of Manu'a (Ta'u & Ofu)
<p>Individual – level Factors</p>	<ul style="list-style-type: none"> *Lack of motivation from peers *Lack of support from families *Culture *Lack of Finances
<p>Structural – level Factors</p>	<ul style="list-style-type: none"> *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

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

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

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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

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 problems, 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 Health 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

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.

Lutita 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 CYSCHN.

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

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 Affairs 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.

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$600,000	\$485,820	\$485,820	\$484,884
State Funds	\$534,000	\$400,000	\$0	\$0
Local Funds	\$0	\$0	\$364,365	\$363,663
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$1,134,000	\$885,820	\$850,185	\$848,547
Other Federal Funds	\$1,054,213	\$850,000	\$95,374	\$263,694
Total	\$2,188,213	\$1,735,820	\$945,559	\$1,112,241
	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$485,820	\$490,711	\$485,500	
State Funds	\$0	\$368,100	\$0	
Local Funds	\$400,000	\$0	\$364,125	
Other Funds	\$0	\$0	\$0	
Program Funds	\$0	\$0	\$0	
SubTotal	\$885,820	\$858,811	\$849,625	
Other Federal Funds	\$595,374	\$211,805	\$728,481	
Total	\$1,481,194	\$1,070,616	\$1,578,106	

	2020	
	Budgeted	Expended
Federal Allocation	\$485,500	
State Funds	\$364,125	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$849,625	
Other Federal Funds	\$400,000	
Total	\$1,249,625	

III.D.1. Expenditures

Financial Narrative Overview

The MCH Title V funding, in conjunction with non-federal state monies (including in-kind local match) and other federal funds, are obligated and expended to support American Samoa's MCH priority needs and Title V requirements. Approximately one third of Title V funding supports Children with Special Health Care Needs (CSHCN) and an additional one-third supports the MCH priorities for preventive and primary care initiatives for children ages 1 -21 years of age. These initiatives include wellness visits and immunizations; oral health; breastfeeding initiatives; RHD screenings and awareness activities. The remaining one third cater to prenatal and postpartum care services, infants less than one year of age, as well as support all MCH staffing efforts and workforce development as well as some Nursing Home visit activities. Local funds appropriated by legislatures to fund housing and utilities at the Program Director's office, MCH clinics, and finance staff (Fiafia Faumuina, Mark Meredith, Levi Reese) are used as in-kind match for local matching. Three of the Title V staff also have 50% of their salaries paid by local funds (State Funds).

Expenditures (FY 2018 Annual Report)

In FY 2018, Title V funds were spent on various MCH activities and initiatives. This narrative correlates with the budget forms in this application and FY 2018 annual report.

Form 2

According to the American Samoa's Title V expenditure report in Form 2, 30.5% of funds were used for preventive and primary care initiatives for children ages 1 to 21 years, and 32.6% of funds were utilized to fund initiatives for children with special health care needs. To date, the Treasury department's electronic financial system, One Solution, is showing that 100% of federal funds has been expended. With additional funds available from the MCH Zika Services grant, resources were leveraged to cover some of previous planned initiatives which freed up Title V funds to cover expenses for other clients served such as pregnant women and infants less than one year as well as other nursing initiatives. Having the Zika funds cover leased expenses such as office lease, transportation and utility fees budgeted for, it freed up federal monies to fund other natives for nursing and other clients served such as pregnant women and infants less than one year of age and other non-MCH clients. This is the reason why there is less money expended for children and children with special health care needs compared to what was previously budgeted for.

As illustrated in Form 2, line 9, "Other Federal Funds," American Samoa's work was also supported by a variety of other federal funds in FY 2018 including the State Systems Development Initiative grant and the CH Zika Services grant. MCH priorities across the Title V population health domains were supported by federal and state dollars in FY 2018. For example, in the Title V child health domain, a state priority is to improve early prenatal care by promoting women's preventive medical visits. American Samoa's performance measures for this state priority focus on improving early prenatal care and women who receives early screening for breast and cervical cancer. Other federal awards that help the territory support this Title V priority include the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV); the American Samoa Community Health Centers (FQHC, HRSA funded); Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Cooperative Agreement for Zika (CDC); Public Health Preparedness and Response (PHPR) for Zika; WIC program; Medicaid; Breast and Cervical Cancer Early Detection (BCCP); Zika Surveillance and Prevention Program (CMS); and Zika Surveillance, Intervention and Referral to Services Program (HRSA), may not be under the Title V administration but helped support this priority and related work in collaborative partnership.

30/30/10 Requirement

American Samoa tracks expenditures to comply with the Title V 30/30/10 legislative requirements. That is, a minimum of 30% of total funding must be expended for CSHCN; a minimum of 30% of total funding must be expended for preventive and primary care for children; and a maximum of 10% of total funding can be expended for Title V administration. In FY 2018, expenditures were tracked by CSHCN; preventive and primary care for children ages 1 to 21 years; pregnant women, mothers and infants; and other. Earmarked expenditures track the required amount, variance, percent of total and percent required to assure legislative compliance. In FY 2018, 32.6% of Title V expenditures were for care coordination and medical care for CSHCN, 30.5% of expenditures were for preventive and primary care for children (including wellness check-up, immunizations, oral health, and RHD prevention); and 0%

were allocated for Title V administrative costs. The remaining 37% of expenditures were for pregnant women, mothers, infants and others. Funding for these populations supported RHD screening, breastfeeding initiatives, referral for tobacco cessation and counselling, and surveillance mechanisms such as teen pregnancy, postpartum and newborn surveillance and ongoing needs assessment.

To assure the 30/30/10 requirement is properly documented and to record expenditures by the MCH Pyramid Services, ASMCH has specific budget project titles in the Expenditure Tracking Spreadsheet it uses. The FY 2018 budget project titles included the following five categories:

- Direct Services Children –MCH
- Enabling Services Children – MCH
- Direct Services Women – MCH
- Enabling Services Women – MCH
- Public Health Functions and Infrastructure – MCH

Expenditures for CSHCN also have specific titles in the Expenditure Tracking spreadsheet (Excel). For the 30% requirement for children requirement, American Samoa tracks related expenditures including Wellness check-up, immunizations for children and adolescents, oral health services for early childhood ages 1-3 years of age.

Annual Report Expended, the following line items were less than 10% of the Annual Report Budgeted due to reallocating of funds to other MCH population (pregnant women, infants and others) since the availability of Zika funds freed up some Title V funds to assist with enabling services and infrastructure building in.

Table 1 summarizes ASMCH spending by the MCH Pyramid of Services (i.e., direct, enabling, and public health services and systems).

TABLE 1. ASMCH Spending by MCH Pyramid of Services and Individuals Served.

Form 5

Form 5 reflects the number and percent of the MCH population served by the Title V program in American Samoa, as defined by both Title V funding and Title V local match. The estimated total count of individuals served was 12,822. The Form 5a count reflects individually-delivered direct or enabling services (i.e., the top two levels of the MCH Pyramid of Services) without reimbursement. This count includes individuals who received a service funded by total federal and non-federal dollars as reported on Form 2, line 8. For FY 2018 reporting, data on individuals served were collected from ASCHC UDS data, Immunization Program, BCCP, Nursing home visits, Postpartum and newborn data, vital statistics, and WIC.

Form 5b provides an estimate on the total percentage of populations who received a Title V-supported service in each of the MCH population groups across all levels of the MCH Pyramid of Services. This estimate includes all individuals and populations served by the total federal and state match as reported in Form 2, line 8. As reported on Form 5b, Title V served an estimated 69% of pregnant women, 52% of infants, 40% of children, 77% of CSHCN and 41% of others which includes males and non-pregnant women of childbearing age.

American Samoa is exploring a variety of ways to expand the reach of Title V. For example, on May 2018, ASMCH and its RHD Advisory Board and partners launched the RHD screening program in the schools. In June, 2019, RHD Clinic opened at Tafuna CHC to provide monitoring and antibiotic treatment every 3 weeks.

Payer of Last Resort

American Samoa DOH strongly supports Title V regulations to use Title V funds as the payer of last resort. The comprehensive Title V-Title XIX IAA draft awaiting the Medicaid director's signature highlights the MCH Program to contract for each local health department includes contractual language which emphasizes this payment structure for programs that provide direct or enabling services to MCH clients. The remaining Title V funds are used for systems-level work in infrastructure or related to the ten essential services which are non-claims related reimbursement.

Challenges

There are some challenges related to the Title V budget. For many years, Title V supported a variety of MCH projects and served as a gap-filling funding source. With the Title V transformation and the most recent five-year needs assessment, new state priorities were identified. Previous state priorities may not have reemerged as priority issues, but still required funding to continue the level of service provision. Likewise, some of the current state priorities are underfunded in relation to other emerging or priority needs. For example, nursing home visits and rise in TB cases necessitated MCH expenditures due to lack of local investments, poor planning and lack of partnerships in these areas. Some priority areas, especially in the adolescent health population domain, currently rely on other funding sources and partners to promote preventive medical services with competitive grants.

III.D.2. Budget

Budget (FY 2020 Application Year)

Together with local funds and other federal funds, the Title V MCH block grant is used to address American Samoa's MCH priority needs, improve performance related to targeted MCH outcomes, and expand systems of care for the MCH and CSHCN populations. American Samoa's Title V Leadership Team—which includes the Title V MCH director, Title V CSHCN director, and key Title V administrative staff—meets on a regular basis to discuss all aspects of Title V, including the budget and how federal and non-federal funds are used to address the state's MCH needs. Table 1 illustrates projected Title V funding allocations for FY 2019.

Table 1. Title V FY 2019 Appropriations by MCH Initiatives

Early Prenatal Care & Well Women's Visits	\$60,000.00
Breastfeeding Initiatives	\$7,000.00
Children's Wellness Visits & Developmental Screening	\$48,455.00
Oral Health	\$20,000.00
RF and RHD School Screening and Treatment (CSHCN)	\$40,000.00
Immunization Coverage	\$3,000.00
Adolescent Health and teen pregnancy prevention	\$3,000.00
Care Coordination and medical home for CSHCN	\$120,000.00
Five-Year Needs Assessment and Public Health Systems	\$161,600.00

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

- NPM 1 (Well-woman Visit)
- NPM 4 (Breastfeeding)
- NPM 6 (Children Developmental Screening)
- NPM 10 (Adolescent Well-visit)
- NPM 11 (CSHCN Medical Home)

At the state level, only NPM 11 will have direct services Title V allocations in FY 2020. This is in part due to the most critical and immediate MCH needs, as well as the need to fill funding gaps that would otherwise exist without Title V funding. Additionally, most of the other activities like NPM 10 are largely supported through the HRSA FQHC funds to the Community Health Centers as well as the CDC Immunization Program funds (to promote HPV vaccinations) which are both administered under ASDOH. The amount above is mostly enabling and public health services related to MCH staffing providing time and effort in policies and attending advisory board meetings such as planned for Adolescent health and immunization program. In FY 2020, the Title V program will revisit these NPMs to determine whether additional Title V support is needed. Notably, ASDOH have identified program work across all NPMs listed above.

Title V funds will also be used at the state level to directly support the work of American Samoa's State Performance Measures (SPMs), as follows:

- SPM 1 (Zika Prevention – Pregnant Women) -in kind since MCH-Zika funds this SPM.
- SPM 2 (Oral Health - Children)
- SPM 3 (Immunizations—Children)
- SPM 4 (RHD Prevention—Children & Adolescents)

SPM 5 (Zika Care Coordination – CSHCN)

All SPMs have robust and continuing line item allocations in the FY 2020 Title V budget, as reflected in Table 1. The state programs and activities that will support work on the above NPMs and SPMs in FY 2020 are detailed in the state action plans.

Budget appropriation are in-kind for Zika initiatives since it now fully funded by the MCH-Zika Services grant. This includes the MCH Epi, Zika Compliance Officer, and Client Navigators. The Others budget will go into executing public health services and systems to include the Five-Year Needs Assessment.

30/30/10 Requirement

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

Population Appropriated	Title V Funds	Percent of Total Funding
<i>Pregnant Women & Infants < 1 Year</i>	\$70,000.00	14
<i>Preventive & Primary Care Services for Children</i>	\$145,900.00	30
CSHCN	\$160,000.00	33
<i>Others</i>	\$109,600.00	23
TOTAL BUDGET	\$485,500.00	100

American Samoa’s commitment to adhere to the 30/30/10 Title V legislative requirement was discussed in the preceding Expenditures section. For FY 2020, this commitment is again reflected in Form 2 (Lines 1A, 1B, and 1C) in the Application Budgeted and in Table 2. For FY 2020, 30% of the total Title V budget is designated for preventive and primary care for children; 33% is designated for Children with Special Health Care Needs; and 0% is designated for administrative costs. Title V leadership will hold budget discussions throughout the fiscal year (in coordination with the DOH Finance Division, ASG Budget and Treasury Analysts) to address any new or unplanned MCH needs.

Form 2

ASDOH barely meets the required Title V state match which is a \$3 match in non-federal funds for every \$4 of federal Title V funds. Majority of American Samoa’s local match is in-kind appropriations. ASMCH “Local MCH Funds” (Form 2, line 3) of \$364,125—which is also considered the state’s applied Maintenance of Effort for Title V—is composed of local funds from Title V staff salaries and also in-kind match of the following ASG personnel and office/clinic facilities: MCH clinics at ASCHC; Central Well Baby clinic and local funded nurse (Sala McMoore), Nursing administration office; DOH Finance office and staff (Fiafia Faumuina); ASG Budget Office and Budget Analyst Shab Pilcher; ASG Treasury office and Treasury Analyst, Levi Reese; Procurement Office and staff, Shirley Laula at Purchasing Division and Lucy Leota at Contracts Division; and this includes all their utilities at well. The majority of this match (approximately 79%) is related to the Needs Assessment and public health services . Along with other federal funds, these state MCH dollars provide a critical component of American Samoa’s MCH infrastructure.

Form 3

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

For example, ASMCH Title V state priority need to “Reduce barriers, improve access, and increase the availability of health services for all populations” aligns with the top level of the pyramid (direct services) through SPM 10, which focuses on care coordination and supporting medical homes for CSCHN. The state priority to “Reduce Rheumatic Fever and Rheumatic Heart Disease” aligns with the top, the middle (enabling services) and bottom level (public health services and systems) of the pyramid through NPM 10 and NPM 11, respectively. State level activities for NPM 10 (Wellness visits for Adolescent) focus on wellness visits and NPM is promoting children accessing medical

homes. The school screening program for RHD will both increase access to medical homes as well as promote preventive medical services for children and adolescents.

III.E. Five-Year State Action Plan

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

State: American Samoa

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

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

Program Purpose and Design

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

Title V continues to operate entirely within the Health Department, under the auspices of the Nursing Division, which the Director of Nursing is also the MCH Program Director. This has been the origin of the Title V program from its inception to the present day. Although the bulk of the MCH staff are non-clinical, there is still a number of nurses providing clinical work who are partially paid under the Title V funding. This linkage of clinical and non-clinical personnel creates a connection of insights from a programmatic perspective, directly linking public health services and enabling services to direct clinical work. This helps the Title V program review efforts that can help bridge existing gaps in the system, and advocate for changes that improve care for its population.

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

Through various ways, Title V has been instrumental in connecting people, programs, systems, and organizations. When opportunities arise, Title V provides presentations on current trends regarding improving systems of care, updating service providers on latest options that are evidence-based and standardized for assessments and approaches. Programs are connected in a way to complement each other while at the same time improving their services for the MCH population. Data systems are examined to determine best approaches for dissemination, assessment and interpretation. And organizations have a better understanding of where we all relate to one another, to better serve our community.

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

The sole purpose for the ASMCH Title V program is to influence positive changes on systems of care that service women and children, including children and youth with special healthcare needs in American Samoa. By engaging with the community and its partners, Title V will be successful in reaching its goals and objectives.

III.E.2.b. Supportive Administrative Systems and Processes

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

MCH Workforce Development

Although the MCH Program has continued to grow over the past couple of years with its roles and responsibilities as well as its workforce, there continues to be challenges that directly impacts the productivity of the workforce and the program as a whole. Combined with the MCH Zika team, there are approximately 11 employees that work directly from within the ASMCH office and are fully or partially funded by Title V funding. However, Title V also pays for partial salary for two nurse practitioners, a registered nurse, a few certified nurse assistants, and two full time health educators. These personnel are assigned to health centers to provide direct services for the MCH population. Title V also pays partial salary for a financial administrator and a newly hired epidemiologist for MCH.

There have been challenges in maintaining team members as some have had to move to the United States to seek medical attention. Of the remaining, these Title V employees also have additional responsibilities within the Health Department that may or may not directly relate to MCH population but impact the health of the community as a whole. Such roles include participating in the Lymphatic Filariasis Campaign, the Meningococcal campaign, and other community events that require full participation from DOH personnel. Ideally, it would be most beneficial if all 13 employees would work full time on MCH initiatives; however, supporting overall health objectives for the department is valuable and significant to the operations of MCH.

Of those working full time on MCH priorities, 2 are seasoned health educators with backgrounds as Nurse Assistants. They are Mrs. Conference Alailefaleula and Mrs. Manulelei Silva-Aitaoto. They are assigned to the Health Centers to provide health education during the prenatal and well baby clinics, as well as to the OBGYN clinic and maternity ward at the LBJ Hospital.

Ms. Tauaofetalaiga Tauanuu was the sole client navigator for the CYSHCN program, who manages close to one hundred families of this group. She has departed the island towards the end of 2018, but has now been replaced by Ms. Florence Tauaefa, who is very efficient in working with the CYSHCN population and their families. Florence continues the work that Tauaofetalaiga has conducted in the past 3 years she has been with the program.

The MCH Data Technician, Ms. Ruta Ropeti, has an Associate of Science Degree from the local community college who works closely with our newly hired Epidemiologist, Ms. Mata'uitafa Fai'ai. Ms. Fai'ai holds a Master's in Public Health with an emphasis on Epidemiological work. Ms. Fai'ai has extensive experience with health projects in American Samoa addressing women's health, actively involving herself in data collection, interpretation, and dissemination.

The MCH Coordinator, Anaise Uso, has worked as a Dentist for the past 18 years, and has extensive experience in school-based preventive dental care for young children. Since her appointment to coordinate the MCH Program, she spends all her time managing MCH, SSDI, and Zika efforts, to say the least. Dr. Uso also participates in Dental activities throughout the year and is a strong advocate for preventive dental work for young children.

Assisting the MCH coordinator is her colleague, Ipuniese Eliapo-Unutoa, who has also worked for MCH for more than 18 years, primarily with the CYSHCN program and the newly assigned Rheumatic Heart Disease (RHD) Control & Prevention Program. Ipu, as many call her, also has used some of her time in the past year to manage the Preventive Health & Health Services Block Grant. Ipu is also the Project Director for the newly acquired Family to Family Health Information Center for American Samoa, as she is also a mother of a child with special needs and has been in the forefront in attaining this assistance for families of CYSHCN in Am. Samoa. Her background is in

Occupational Therapy; however, she spends majority of her time performing administrative responsibilities for Title V and RHD.

The Program Director for MCH, Mrs. Margaret Sesepasara, is also the Director for the Nursing Division; she houses an office assistant, Tolu Tava, who also manages financial reports for the Title V and MIECHV programs. Other responsibilities include office management, clerical duties that support the Regulatory Board and the Nursing Administration, securing resources to support nursing home visitations to hospital discharge referrals, and all meetings that are required for the Director of Nursing/MCH Program Director. All MCH activities and reports are directed to the Program Director's office for guidance and recommendations.

Aside from her managerial positions, it should also be mentioned that the Program Director is a Nurse Practitioner by profession. She, along with a colleague who is also a Nurse Practitioner, Mrs. Tele Hill, has worked for MCH and Department of Health for more than 30 years. They provide clinical support within the prenatal and Well-Baby clinics at the satellite health centers, as well as home-visitations for the Elderly, the chronically ill, and the special needs population per referral requests. A registered nurse was also funded by MCH Title V during 2018, who assisted in RHD clinics and maintained operations for the central primary clinic. However, she was transferred to the Tafuna Family Health Center to conduct quality improvement work, and has recently been transferred under the Health Center funding for compensation. Presently, the RN position is vacant.

Staff recruitment and retention is a challenge for MCH among other things. Its been several years since annual governmental increments have been granted for career service employees, so retaining those who have been trained and are experienced in the field is very difficult. The hiring process through the government is extremely frustrating and lengthy, affecting recruitment of the most qualified applicants. Most often, applicants with clinical training are preferred to those without a clinical background. This is to accommodate shortages of clinical support when the need arises; however then, programmatic activities are put on hold.

MCH staff takes advantage of training opportunities that promote skill advancement for the work they perform daily. One staff has completed the Data for Decision Making (DDM) coursework while two have just a few classes to take. The DDM class includes 5 modules that teaches health workers on how to be epidemiological techs and assist in gathering data, analyzing and reporting results. A few of the MCH staff have also participated in the Mental Health training hosted by the local AHEC office.

Challenges will continue to exist in the MCH workforce. With limited funding to support additional staffing, the existing workforce has and will continue to learn to assist one another in addressing priority needs. Cross training has been a continued strength of the ASMCH team, specifically when it calls for public outreach, island-wide emergency responses to natural disasters, and departmental activities.

In moving forward, prioritization of recruitment and retention is necessary to reach goals for the following years. MCH leaders will have to work on salary adjustments to compensate additional skills and years of experience across the workforce. Specific roles and responsibilities should be assigned together with appropriate training so that each personnel can feel competent to handle the work given. Each team member should be able to contribute to the overall Title V components throughout the year, preparing them for increased responsibilities and management skills for future advancement.

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

basis.

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

A. Advisory Groups.

Family involvement in MCH led advisory groups are very significant in many ways. In the past year, family representatives from different backgrounds and economical status contributed their knowledge to the evolving needs of the community on healthcare issues. We continue to learn that one parent/family perspective does not comprehensively represent the variations of experiences that need to be shared among advisory groups that are created to effect change. By recruiting more family representatives, advisory groups can integrate their valuable input to improve systems of care and delivery of services for all MCH population.

B. Strategic and Program Planning

Family Representatives have been instrumental in all sectors of MCH this past year, contributing to strategic plans and program effort. Opportunities were created to allow families of women and children, including children and youth with special needs to provide input that was valuable to the improvement of services and delivery of healthcare for their loved ones. Without these insights, it would be difficult to meet specific needs of the community.

C. Quality Improvement

The MCH is currently working on revising and re-establishing the MCH website, however, there is a Facebook Page for the ASMCH that is consistently being updated with helpful information that pertain to women and children from national and local partners. Also, public service announcements and videos are posted on this page and to date, there are more than 400 followers who read our posts and comment.

Although media outreaches have been mentioned in the past applications, Title V has not been successful in sponsoring public announcements as much as it had originally planned. This is mainly due to funds being reallocated to other pressing needs, therefore limiting the ability to get MCH messages out to the public.

D. Workforce Development and Training

ASMCH has participated in various trainings throughout the year 2018. Such trainings include a parent workshop hosted by special education division, the mass drug administration (MDA) for lymphatic filariasis, and the meningococcal campaign. Other opportunities for training were based on overall DOH projects that required attendance from the MCH staff. All navigators are fully engaged with their clients and families so as to improve the quality of their services through self-evaluation and constructive feedback. This is done on a daily basis.

E. Block Grant Development and Review

Family Representatives have been involved from the beginning of the five-year cycle for MCH applications. Continually, parents and family members are invited to quarterly meetings that discuss issues related to the selected priorities and how these apply to the AS population. Their input help to update the needs assessment on the MCH population, as well as realigning priorities that are consistent with current healthcare issues and specific family needs in the island. Family Representatives are also given the opportunity to review its block grant content and provide feedback as deemed necessary.

F. Materials Development

Families play a huge role in the development of materials and health literacy within MCH. Families are asked to comment and make necessary recommendations on brochures, banners, pamphlets and other reading materials that are available for review. Materials are produced in both Samoan and easy English language to accommodate the community.

G. Program Outreach and Awareness

ASMCH has been involved in many outreaches all year long. Such outreaches include governmental functions that involved health booths out in the communities. Parents and Family Representatives are invited to join MCH at these functions to talk to other family members who may have questions or concerns that only a family member can relate to, and then to share pertinent information about MCH and its purpose in the community. Parent Representatives are asked to go on local television programs with MCH staff to discuss breastfeeding, RHD, prenatal care, and children with special healthcare needs.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

ASMCH goals and objectives for the State Systems Development Initiative (SSDI) project align with state priorities (1) to enhance data and analytic capacity to identify priorities; (2) to inform program resource allocation, needs assessment and program evaluation; (3) and to provide ASMCH program and related workgroups with in-depth data analysis and interpretation to guide efforts to improve health among MCH populations. SSDI Project currently funds salaries for the MCH Data Tech, Ruta Ropeti and an IT Manager, Sam Tagaloa. They are both instrumental in accessing and collecting data from various DOH databases and electronic medical records.

In 2018, ASMCH Title V's SSDI activities were primarily aimed at building on existing coordination with and capitalizing on its existing partnership with the ASDOH Epidemiologists and Public Health Surveillance office resources to inform the Title V block grant. Ms. Ropeti, worked closely with Territorial Epidemiologist Aifili John Tufa, and later in October 2018, MCH Epidemiologist, Mata'uitafa Faiai, to collect and report on all MCH Surveillance data needed to track and monitor NPM, SPM and NOMs. This is the core MCH Epi Team. The MCH Epi team meets regularly with key Title V staff and the key senior leaders and medical staff to report on MCH data updates, provide recommendations for solutions to improve findings if warranted

The ASDOH Public Health Surveillance Office is managed by Mr. Tufa, who oversee all Epi efforts including reportable diseases, syndromic surveillance, vital records, validating UDS data and other program data. This office also house BRFSS and is responsible for all DOH Data Surveillance oversight. MCH Epi team works closely with Mr. Tufa for epidemiologic support to ensure ongoing Title V needs assessment are carried out accordingly.

Having direct and timely access to MCH health data is another important component of the Title V performance monitoring process. American Samoa Vital Records files (Live Birth, Fetal Death, linked infant death/live birth files, linked Maternal Mortality Files) and other data sources are collected by the Public Health Surveillance office, and oversee by the ASDOH Epidemiologist.

Since MCH Epi, Ms. Faiai, joined the MCH workforce, she has been instrumental in overseeing all MCH Surveillance and Reporting for the Department of Health. She is fully funded by the MCH-Zika Services grant. As part of the American Samoa SSDI project, the Data Tech routinely collects and reports on certain MCH Health Indicators and reports to the MCH Epi, who then informs clinical supervisors on these findings and recommendations made to improve these irregularities. Clinical in-service trainings are then implemented to improve documentation and clinical capacity. Example providing surveillance over delivery and birth records, analyzed, interpreted and communicated not only to Title V staff but to MCH stakeholders working to reduce infant mortality and other adverse birth outcomes in the territory. SSDI initiative fosters timely data collection, identify needs for quality improvement projects and provides recommendations to improve on these findings.

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

ASMCH is looking forward to the results of the American Samoa MCH Jurisdictional Survey implemented in June

2019. Half of the SSDI funds have been reallocated for the past two years to completing MCH jurisdictional surveys for all the US territories. Findings will be instrumental in completing the Five-Year Needs Assessment due July 2020.

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

In the past year, MCH continues to explore ways to contribute to improving the healthcare delivery system in Am. Samoa for its population. Although all community health clinics have made their services free, except for pharmacy services as this still operates under the local hospital, there are still limitations to the types of services available at each of the clinics. Accessing healthcare services at the LBJ Tropical Medical Center, the only hospital in the territory, means a facility fee is initially required. This facility fee is ranged from ten to twenty dollars per visit, depending on one's residential status; however, many families are not able to afford this facility cost. This has often become the main barrier for many families who are seeking care for their children.

Specialized clinics also are executed in the hospital as it houses all supporting services that are required for these clinics. Such specialized clinics include Audiology & Ophthalmology for the Zika population, Pediatric Cardiology for RHD, and Shriners for Orthopedics and CYSHCN. These populations are still required to pay for the facility cost before accessing these specialized services. MCH has worked with the finance office at the local hospital to ensure these families and their children have full access to these services. CMS funded Zika grant issues appointment passes to MCH Zika Navigators who work closely with families to ensure they access their required Ophthalmology and Audiology services. 2018 was the first year the annual cardiology clinic was held at the Department of Health central Primary Clinic. Families received services without a cost.

Other challenges exist among the MCH population besides paying for a facility fee. When children with special needs require certain medical equipment or devices, there is no insurance plan or funding source to cover these costs. A pediatrician may order the initial equipment or device and charge it on Medicaid for an inpatient, however, once that child leaves the hospital, the family is on its own to find and fund a replacement. If a referral is made to Department of Health, a nursing home visit is conducted and the task of searching and at times, paying for the this device or equipment is assigned to these nurses, which is often out of their pockets.

This is not a system that Title V neither supports nor endorses, so we continue to investigate ways that ensures a comprehensive system of care, which warrants quality healthcare services for women and children, including children and youth with special healthcare needs. As Title V and Title XIX continue to finalize its Inter-Agency Agreement, there is still much more work to be done at clarifying types of services and their costs, how Medicaid pays for these services, and to which populations these provisions are available for. There is much to understand about how the local laws and changes in politics impact the relationship between Titles XIX and V. ASMCH will continue to intervene as necessary for its population.

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

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	4.2 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	12.3	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID	Data Not Available or Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	38.4	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures

**NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives**

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

State Provided Data			
	2016	2017	2018
Annual Objective	0.1	0.2	9.7
Annual Indicator	9.4	9.5	27.5
Numerator	918	921	2,633
Denominator	9,720	9,720	9,561
Data Source	Postpartum Data	Postpartum Data	CHC UDS Report, US Census International Database
Data Source Year	2016	2017	2018
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9.9	10.0	10.5	11.0	11.5	12.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			50	
Annual Indicator	30	40	62.5	
Numerator	3	4	5	
Denominator	10	10	8	
Data Source	DOH Media	DOH Media	DOH MCH Media	
Data Source Year	2016	2016	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	60.0	70.0	80.0	90.0	100.0	70.0

ESM 1.2 - Percent of women registered during Women’s Health Week for a preventive screenings.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	35.0	36.0	37.0	38.0	40.0	

ESM 1.3 - Percent of Pregnant Women who has heard of the “Fight the Bite” Zika Campaign

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	1.0	2.0	3.0	4.0	5.0	

State Performance Measures

SPM 1 - Percent of Pregnant Women who tested Positive for Zika.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		20	19	
Annual Indicator	23.6	23.6	0	
Numerator	49	49	0	
Denominator	20,789	20,789	931	
Data Source	RHD registry 2016	RHD registry 2016	AS DOH Surveillance Office MCH Postpartum LBJ Nur.	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	18.0	17.0	16.0	15.0	14.0	0.0

State Action Plan Table

State Action Plan Table (American Samoa) - Women/Maternal Health - Entry 1

Priority Need

Promote preventive medical visits for women ages 21-44.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

By 2020, increase by 3% the proportion of women ages 21 to 44 who gets breast and cervical screening done.

Strategies

- Utilize peer groups, social media and social networks for women (village Tinifu and church groups) to promote and support, Breast and Cervical Cancer screening program.

- Formulate and disseminate a women check-up passport to improve tracking and monitoring of age appropriate visits and screening appointments.

- Implement a Women’s Health week promotion in the month of May to promote preventive screenings.

ESMs	Status
ESM 1.1 - Number of media outlets utilized to promote preventive medical visits.	Active
ESM 1.2 - Percent of women registered during Women’s Health Week for a preventive screenings.	Active
ESM 1.3 - Percent of Pregnant Women who has heard of the “Fight the Bite” Zika Campaign	Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (American Samoa) - Women/Maternal Health - Entry 2

Priority Need

Reduce pregnant women diagnosed with Zika viral infection.

SPM

SPM 1 - Percent of Pregnant Women who tested Positive for Zika.

Objectives

By 2020, decrease the percentage of pregnant women with Zika virus infection to zero.

By 2020, increase percentage of pregnant women accessing early prenatal care at first trimester to 44%.

Strategies

Support collaborative efforts with partners to provide ongoing mass media campaign, "Fight the Bite".

Collaborate with all Prenatal Providers and supporting programs (BCCP, MEICV, NCD, Intersections Inc., WIC) to promote early prenatal care services.

Provide public service announcement videos and mass media campaign to promote pregnant women seeking early prenatal care.

Implement Centering Pregnancy Curriculum at the Tafuna Prenatal Clinic

Last Year (2018) Accomplishments

OBJECTIVE 1.1: By 2020, increase percentage of women with a preventive medical visit in the past year by 44%.

According to the Uniform Data System (UDS) for the Federal Qualified Health Centers (FQHC), 2,663 woman received care through clinics that are supported by the MCH Title V program. This is about 41% of the total estimated number of women in American Samoa in 2018. Services offered through the community health clinics include primary care for non-communicable and communicable diseases, dental, pap smears, clinical breast exams, and screenings for depression and tobacco use. Services provided through the community health clinics were either based on public health services, enabling services, or direct services.

Objective 1.2 : By 2020, increase the percentage of women accessing prenatal care at 1st trimester by 10%.

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester.					
	2014	2015	2016	2017	2018
Annual Indicator	34.8	34.6	41.7	39.2	35.3

In 2018, the percentage of women accessing prenatal care at first trimester decreased by 4% from 39% to 35%. It is apparent that the percentage of pregnant women seeking initial care at first trimester continues to decline. The highest percentage (41%) for women seeking care during their first trimester was noted back in 2016, when Zika was declared an outbreak, and mass media campaigns saturated the territory urging pregnant moms to come in for early prenatal care. The years before and after 2016 noted percentages remaining within the thirties. Consistently throughout the years, data confirms that women continue to seek initial prenatal care at their second trimester in both the local hospital and community health centers.

Objectives: 1.2. By 2020, increase by 3% the proportion of women ages 21 to 44 who gets breast and cervical screening done.

The Breast & Cervical Cancer Program (BCCP) reported serving 232 non pregnant women in 2018, between the ages of 22 to 44. The Community Health Center reported 159 women received a pap smear test at their facilities. Due to lack of providers and mediocre hiring process, this objective did not improve as planned.

OBJECTIVE 2.1. By 2020, decrease the percentage of pregnant women with Zika infection by 5%.

The MCH Program continues to support collaborative efforts with key partners to provide ongoing mass media campaign, "Fight the Bite". Spearheading this initiative is the Emergency Preparedness and Response Division. Radio spots are aired during the heaviest rain season usually around December to March. Electronic boards are also utilized as well as social media, television announcements and departmental road-side waves (quarterly). American Samoa is warm, humid and rainy year-round, but there is a long, wet summer season which is usually from October to May. This is usually the season when the campaign is made due to the increase of mosquitoes breeding grounds around this period. The Community Health Centers also continue to make condoms accessible for women including pregnant women whom may be concern with getting Zika through sexual intercourse.

The MCH Health Educators also promotes zika virus infection prevention talks for pregnant women during prenatal visits. According to the American Samoa Department of Health Surveillance, there were no women reported to

be diagnosed with Zika during Pregnancy in 2018 from January to December. This objective has been accomplished.

One of the biggest campaigns for the local health department in American Samoa for last year was for Lymphatic Filariasis Mass Drug Administration. The MCH Title V program contributed staff and resources to assist in this effort. Lymphatic Filariasis continues to be heavily present in the Samoa Islands, and 2018 was the first year of a 2 year campaign. The count of women ages 19-44 who received medication from this effort was 4,759.

Title V funds a portion of the Salary of the Preventive Health & Health Services Block Grant Coordinator, as she also manages the Rheumatic Heart Disease (RHD) Program, the Family to Family Health Information Center grant, and coordinates the CYSHCN Program. Funds for the PHHS Block Grant were used in 2018 for various programs that also catered to women in the community and their health needs. Such programs included wellness outreaches, mothers of children born with hearing impairment, women previously discharged from a hospital setting requiring an initial home-visit, and women who were screened through RHD community outreach clinics.

Strengths:

- Community Health Centers - Prenatal clinics continue to provide healthcare services at no cost to all women seeking medical care at the Community Health Centers until September 2019. There are efforts to strategize how to continue accessible care to those who can't afford to pay after September 2019, however, specifics are not yet available.
- Prenatal Care – Pregnant Women are encouraged to attend early prenatal care visits free of charge. A dedicated provider continues to serve the pregnant women population at the Tafuna Family Health Center, which is located at the most populated area of the island. Nurse practitioners who are also partially funded by Title V continue to provide care for after hour clinics for all women at the health centers.
- Breast and cervical Cancer screening - are accessible at the Community Health Centers afterhours beside the BCCP clinic at Fagaalu.
- Family Planning – Family planning services are now offered for women at the community health centers with CMS funding for CHCs. Birth Control Methods are available at no cost to all pregnant women for prevention of Zika transmission. Pregnant women are also able to schedule an appointment for after giving birth to receive family planning.
- MCH Epidemiologist- Surveillance for women's health is improving as Title V has attained an epidemiologist that is focusing on improving data capacity for all MCH populations.

Challenges:

- Shortage of Clinical Providers- The community health clinics continue to face difficulty in acquiring clinicians to provide specific care to women in the territory. One additional provider was hired on to address the need for the prenatal clinic in the Tafuna Family Health Center. The expectation was for this provider to also provide care for non-pregnant women seeking care at the health centers. However, the provider requested to provide care for pregnant women only. Non-pregnant women were then referred back to LBJ hospital for care or reappointment to see a nurse practitioner for the after-hour clinics. This issue has likely contributed to women discontinuing to seek preventive care through 2018.
- Community Health Centers – CHCs across the islands continue to increase access to care for pregnant women and their newborn infants across the islands. However, women are still have to travel to LBJ for lab work. Women have to pay between \$70 - \$90 for laboratory tests at LBJ Hospital if they don't receive a waiver form from the Zika office. Currently, with the outbreak of Zika, all laboratory tests and visits are free to the woman who utilizes prenatal services at the Community Health Centers. However, there are differences in what is available at each health center. For example, if a woman seeks care at Amouli satellite center, they can register but will have to still travel to the LBJ hospital to get blood work done as there are no phlebotomists at this center. And traveling to LBJ Hospital means another hour ride on public transportation. This is a tremendous challenge as buses are seldom throughout the day to this end of the island. This is also true for Leone satellite Health Center.

- Lack of Community Outreach- There has been minimal outreach campaigns to address women's health in the territory for 2018. There were numerous underlying factors that contributed to the lack of outreach efforts, such as lack of a combined effort among all programs addressing women's health. Additionally, there were competing health campaigns throughout the year that afforded less time to plan, coordinate and execute community outreaches for women's health.
- Media Campaign under-utilization- Media campaigns promoting women's health were minimum in 2018. Although during the Lymphatic Filariasis, women were used to create mass media messages for the public, specific messages addressing women's health were but a few. These messages included family planning clinics and services that were made available, as well as promoting cancer screening for breast and cervix during their designated month (October).
- Other competing health campaigns- Other health campaigns include Lymphatic Filariasis Mass Drug Administration, Meningococcal Campaign, RHD screening campaign, Hybrid Survey, and local territorial events (Flag Day, Coastal Week, hosting the Secretary of Interior) that require all government employees to participate.

Women/Maternal Health - Application Year

Current Activities (FY19)

- The community health centers are continuing to serve non pregnant women through the primary care clinics and women's health evening clinics.
- The health centers also have been able to provide birth control methods for women who are interested without cost, through funding from the Zika Centers for Medicare and Medicaid Services (CMS) grant. These birth control methods are being purchased at a very affordable rate through the 340B Federal Discount Program.
- ASMCH, WIC and Aiga Manuia MIECHV continues to support and promote pregnant women seeking early prenatal care in collaborative efforts together with OBGYN clinicians.
- The Breast and Cervical Cancer Program (BCCP) is currently partnering and planning with Non-Communicable Disease (NCD) Programs and Title V to execute a territorial wide registration for all women to receive health screenings from the Health Department.
- Wellness Programs such as the Slimmer Stronger You (SSY), Obesity Awakening Movement (OAM), and community outreaches on healthy eating and physical activity are enrolling a high volume of women to take better care of their health. These programs are currently contracted by the DOH Preventive Health & Health Services Block Grant.

Plan for Coming Year (2019-2020)

OBJECTIVE 1.1: By 2020, increase percentage of women with a preventive medical visit in the past year by 44%.

Strategies:

1.1.1 Provide mass media campaign to promote preventive medical visit for women.

ESM 1.1: Percent of women participating in community outreach preventive medical services by the CHC primary care clinicians.

OBJECTIVE 1.2: By 2020, increase percentage of pregnant women accessing early prenatal care at first trimester to 40%.

Strategies:

1.2.1 Collaborate with all Prenatal Providers and supporting programs (BCCP, MEICMV, NCD, Intersections Inc., WIC) to promote early prenatal care services by promoting centering pregnancy curriculum STRONG

1.2.2 Provide public services announcement videos and mass media campaign to promote pregnant women seeking early prenatal care.

1.2.5 Ensure all health education materials and resources (Becoming a Mom curriculum) are translated appropriately and standardized across all prenatal clinics.

1.2.3 Ensure all clients understand each session by having a pre and post-test to evaluate efficacy of the materials.

1.2.4 Have appropriate handouts or reminders of each health education topic.

ESM 1.2: Percent if pregnant women participating in the STRONG centering pregnancy afterhours clinic.

OBJECTIVE 1.3: Increase by 3% the proportion of women ages 21 to 44 who gets breast and cervical screening done.

Strategies:

1.3.1 Utilize peer groups, social media and social networks for women (village Tinifu and church groups) to promote and support, Breast and Cervical Cancer screening program.

1.3.3 Formulate and disseminate a women check-up passport to improve tracking and monitoring of age appropriate visits and screening appointments.

1.3.4. Implement a community outreach during Women's Health week in the month of May to promote preventive screenings.

ESM 1.3: Percent of women registered during the Women's Health week for preventive screenings including cervical cancer screening.

OBJECTIVE 2.1. By 2020, decrease the percentage of pregnant women with Zika infection by 5%.

Strategies:

2.1. Provide at least one Zika prevention 101 session to all pregnant women during prenatal visits.

2.2 Track and monitor all pregnant women diagnosed with Zika and refer to Zika Client Navigators once babies are delivered.

2.3. Provide a Zika Roadmap to each pregnant woman diagnosed with Zika

2.4. Support collaborative efforts with partners to provide ongoing mass media campaign, "Fight the Bite".

2.5. Support collaborative efforts to implement Mosquito Action Day, a community outreach health fair, four times a year.

ESM 2.1: Percent of Pregnant Women who has heard of the "Fight the Bite" Zika Campaign.

Perinatal/Infant Health

Linked National Outcome Measures

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

National Performance Measures

**NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives**

NPM 4A - Percent of infants who are ever breastfed

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

State Provided Data			
	2016	2017	2018
Annual Objective	82	83	86
Annual Indicator	76	75	68.2
Numerator	765	750	626
Denominator	1,007	1,000	918
Data Source	American Samoa WIC	Postpartum Data	AS WIC, MCH Postpartum and LBJ Nursery,
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	86.7	87.0	87.5	88.0	88.5	88.5

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	20	21	43
Annual Indicator	54.3	52.1	44.3
Numerator	486	521	407
Denominator	895	1,000	918
Data Source	AS WIC	ASWIC	AS WIC, MCH Postpartum and LBJ Nursery,
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	43.5	44.0	44.5	46.0	46.5	47.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Number of MCH staff attended the Certified Lactation Counselor training.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			19	
Annual Indicator	0	18.2	0	
Numerator	0	2	0	
Denominator	13	11	13	
Data Source	ASMCH	ASMCH	AS MCH	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	21.0	22.0	23.0	24.0	24.0

ESM 4.2 - Percent of women participating at the Breastfeeding Week activities who confirm they are breastfeeding.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		49	14	
Annual Indicator	14.4	13.2	23.8	
Numerator	110	113	134	
Denominator	765	856	562	
Data Source	WIC, CHC	WIC, CHC	WIC and MCH Health Educator	
Data Source Year	2015	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	14.1	14.5	15.0	16.0	17.0	24.0

ESM 4.3 - Percent of postpartum mothers reported that they received breastfeeding resources and reminders after delivery and before discharge.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	60.0	61.0	62.0	63.0	64.0	

State Action Plan Table

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

Priority Need

Promote breastfeeding for infants 0-6 months.

NPM

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

Objectives

By May 30, 2019, increase the percent of infants who ever breastfed by 2%.

By May 30, 2019, increase the percent of infants breastfed exclusively through 6 months by 2%.

Strategies

Provide breastfeeding educational resources in all MCH clinics that are standardized and comprehensive messages for women and families.

Align and strengthen infant feeding education and support through existing programs, including Prenatal clinics, WBCs, home visiting, and WIC.

Promote referrals to the MCH Certified Lactation Counselor and WIC breastfeeding peer counselors for breastfeeding support and counseling.

Revamp the Breastfeeding Coalition to plan a Breastfeeding Week celebration in August.

Promote and support breastfeeding in the workplaces such as supporting government employees' 2 hours break for breastfeeding (BF executive order).

ESMs

Status

ESM 4.1 - Number of MCH staff attended the Certified Lactation Counselor training.

Active

ESM 4.2 - Percent of women participating at the Breastfeeding Week activities who confirm they are breastfeeding.

Active

ESM 4.3 - Percent of postpartum mothers reported that they received breastfeeding resources and reminders after delivery and before discharge.

Active

NOMs

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

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

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

Perinatal/Infant Health - Annual Report

Last Year (2018) Accomplishments

Perinatal/Infant	Count	Site for Service
Number of Pregnant Women	925	CHC
1 st visit at First Trimester	324 (35%)	CHC
1 st visit at Second Trimester	353 (38%)	CHC
1 st visit at Third Trimester	162 (18%)	CHC
Number of Deliveries	931	LBJ Hospital & Home Deliveries
Home Deliveries	5	Home or En route to Hospital
Hospital Deliveries	926	LBJ Hospital
Live Births	918	LBJ Nursery
Stillbirths	13	LBJ Nursery
Infant Deaths	5	LBJ Nursery

Objective 3.1: By 2020, increase the percent of infants who ever breastfed by 5%.

Objective 3.2: By 2020, increase the percent of infants breastfed exclusively through 6 months by 2%.

WIC Data

National Rate	2012	2013	2014	2015	2016	2017	2018
Ever Breastfed 75%	76%	78%	82%	81%	76%	75%	72%
BF 6 mos 43%	62%	63%	65%	60%	54%	52%	49%
BF 12 mos 22%	51%	47%	49%	45%	40%	37%	33%
BF Exclusive 3 mos 33.6%	18%	39%	54%	41%	20%	13%	20%
BF Exclusive 6 mos 14.1%	5%	18%	40%	19%	9%	8%	13%

WIC Rate	2012	2013	2014	2015	2016	2017	2018
Ever Breastfed 67.5%	76%	78%	82%	81%	76%	75%	72%
BF 6 mos 33.7%	62%	63%	65%	60%	54%	52%	49%
BF 12 mos 17.5%	51%	47%	49%	45%	40%	37%	33%
BF Exclusive 3 mos 25.5%	18%	39%	54%	41%	20%	13%	20%
BF Exclusive 6 mos 9.2%	5%	18%	40%	19%	9%	8%	13%

Healthy People 2020	2012	2013	2014	2015	2016	2017	2018
Ever Breastfed 81.9%	76%	78%	82%	81%	76%	75%	72%
BF 6 mos 60.5%	62%	63%	65%	60%	54%	52%	49%
BF 12 mos 34%	51%	47%	49%	45%	40%	37%	33%
BF Exclusive 3 mos 44.3%	18%	39%	54%	41%	20%	13%	20%
BF Exclusive 6 mos 23.7%	5%	18%	40%	19%	9%	8%	13%

In the local WIC data reported in tables above, its comparing their rates from years 2012 to 2018. These trends are then separately compared to the National level, WIC level and Healthy People 2020 Objectives. It is obvious that there is a gradual decline throughout the years since 2014. Despite the rate decreasing for women who initiated breastfeeding, those who did breastfeed, are showing an increase by 5% those who exclusively breastfed their babies up to 6 months of age. This is a small victory and the Breastfeeding Coalition will continue to promote breastfeeding across agencies.

Various strategies were implemented to support these initiatives. The American Samoa Government continues to support the breastfeeding executive order which offer its employees who were newly lactating mothers (up to 6 months after delivery) two hours breastfeeding, daily. Mothers were allowed to either break off during the day depending on their schedules approved by their supervisors to either pump and store their milk, or deliver them to wherever their infants were cared for during the day (home, daycare etc.).

MCH Health Educators, Conference Alailefaleula and Manulelei Silva-Aitaoto, continue to be instrumental in promoting breastfeeding before, during and after delivery at medical clinic settings. They both provide health education in various venues weekly, including all CHC Prenatal Clinics, Well Baby Clinics and OBGYN clinic and ward.

At the LBJ Hospital labor and delivery room, mothers are with their babies to hold with uninterrupted and continuous skin-to-skin contact immediately after birth and until the completion of the first feeding, unless there are medically justifiable reasons for delayed contact. Routine procedures (e.g., assessments, Apgar scores, etc.) are done with the baby skin to skin with the mother. Procedures requiring separation of the mother and baby (bathing, for example) are delayed until after this initial period of skin-to-skin contact, and should be conducted, whenever feasible, at the mother's bedside.

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

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

On August 1-7, 2018, ASMCH, WIC and the Community Health Centers celebrated National Breastfeeding Week with the them, "Foundation of Life." A mass media campaign started a week early through various media outlets including radio stations, local newspaper, social media and local television KVZK *Tafesilafa'i* and *O Lou Soifua Malolo'ina* Programs. Activities were held in various sites listed below and a total of 134 women participated. They also brought their children, grandparents and other members of their families. Presentations for both staff and clients were provided including the benefits of Breastfeeding and common FAQs, positioning and latching demonstrations. Incentives were given out to participants including Breastfeeding bags with drapes, key chains, MyPlate booklets, pens, pencils, coloring books, baby bibs, BF magnets, oranges and water.

Hospital-OBGYN Prenatal Clinic: 28

DOH-Tafuna Prenatal Clinic: 22

DOH-Amouli Prenatal Clinic: 17

WIC-Tafuna Clinic: 14

DOH-Leone Prenatal Clinic:

Perinatal Mortality Concerns

NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths (Stillbirths and infants less than 1 week old).					
	2014	2015	2016	2017	2018
Annual Indicator	14.9	10.0	12.8	8.0	18.3
Numerator	16	11	13	8	17
Denominator	1072	1096	1018	1004	931

There is an alarming rate of perinatal mortality with majority of births not yet full term (<37 weeks) as well as having low birth weights. ASMCH will be working closely with the Territorial Epidemiologist as well as the Nursing office to conduct a full investigation into finding out if past years were under reported or if there are specific causes that may have led to the significance in the high perinatal rate of 18.3 per 1000 live births plus fetal deaths. This rate consists of 13 fetal demise and 4 infant deaths at 7 days of life. This justifies the importance of activating a Fetal Infant Mortality Review (FIMR) taskforce or committee to look into possible risks and causes which can be utilized to formulate policies and a strategic plan that can be implemented to reduce this burden.

Strengths

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

Challenges

- LBJ Hospital is not a Baby Friendly hospital. Formula are still seen at nursery being fed to babies if mothers consent to it even if they can breastfeed or not.
- Breastfeeding Coalition only meets once or twice a year, usually to share data and to plan for the National Breastfeeding Week.
- The Lymphatic Filariasis Mass Drug Administration campaign limited efforts to provide outreach activities at the workplaces as planned.

Perinatal/Infant Health - Application Year

Current activities for 2019

- ASMCH continue to collaborate with partners such as WIC, Aiga Manuaia MIECHV program, OBGYN and CHC Prenatal Clinics and promote early prenatal care and compliance with attendance of all prenatal appointments. All pregnant women are encouraged to breastfeed before, during and after delivery.
- The MCH Health Educators continue to work closely together with the American Samoa WIC Breastfeeding Peer Counselors to promote exclusive breastfeeding. Standardized breastfeeding information are being disseminated in all Prenatal, OBGYN and WIC clinics to encourage and provide support for expecting and breastfeeding mothers on a daily basis.
- WIC Program reaches an average number of 120 pregnant and breastfeeding mothers on a monthly basis. WIC BFPC program will continue to conduct outreach activities, training, and expanded access to services for FY2019.
- The MCH Program and WIC are currently prepping for Breastfeeding Week scheduled for August 1 – 7, 2019. Mass media campaign will be carried out for at least a week before during and after the BF week. All media outlets will be utilized including radio stations, local newspaper (BF Proclamation), local television KVZK and social media. Promotional activities will be conducted in all community health centers, Fagaalu central Well Baby Clinic, LBJ OBGYN clinic and WIC centers.

Future Plans 2020

- Breastfeeding Coalition will utilize social media to promote early prenatal care and encourage pregnant women to pledge “Breastfeeding my Baby exclusively for 6 months”.
- Continue to align and strengthen infant feeding education and support through existing programs, including Prenatal clinics, WBCs, home visiting, and WIC.
- Promote referrals to the MCH Certified Lactation Counselor and WIC breastfeeding peer counselors for breastfeeding support and counseling.
- Implement Breastfeeding Week celebration in August 3 – 7, 2020.
- Promote and support breastfeeding in government and non-governmental workplaces such as supporting at least 2 hours break for breastfeeding.
- Conduct a BF workgroup to draft and approve the American Samoa Territorial Breastfeeding Plan.

Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 6

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives

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

State Provided Data			
	2016	2017	2018
Annual Objective			5
Annual Indicator	2.5	2.5	1.3
Numerator	180	180	49
Denominator	7,339	7,339	3,861
Data Source	Part c and MEICHV	Part c and MEICHV	MCH CSHCN and Part C Helping Hands Early Intv.
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	10.0	15.0	20.0	21.0	22.0	10.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Number of Providers utilizing a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		51	40	
Annual Indicator	20	30	27.3	
Numerator	2	3	3	
Denominator	10	10	11	
Data Source	CHC Data	CHC Data	CHC UDS	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	60.0	70.0	80.0	90.0	40.0

ESM 6.2 - Percent of clinical staff trained in the standing operating procedures for referrals to Early intervention and other programs.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	50.0	55.0	60.0	65.0	70.0	

ESM 6.3 - Percent of participants in Children’s Oral Health awareness month activities.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	10.0	15.0	20.0	25.0	30.0	

State Performance Measures

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			1	
Annual Indicator	0.9	0.4	1.1	
Numerator	29	14	44	
Denominator	3,200	3,200	3,861	
Data Source	CHC Dental Clinics	CHC Dental Clinics	Tafuna CHC Dental Clinic	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.0	3.0	4.0	5.0	6.0	2.0

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			4	51
Annual Indicator	51.3	40.1	60.2	
Numerator	1,144	1,130	576	
Denominator	2,230	2,820	957	
Data Source	AS IP	ASIP	Immunization Office Registry Web IZ US Census Int.	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	51.2	51.5	52.0	53.0	54.0	65.0

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			29	
Annual Indicator	23.6	28.9	15.1	
Numerator	49	60	20	
Denominator	20,789	20,789	13,248	
Data Source	RHD registry 2016	RHD registry	MCH RHD Registry (BYU, OSHU, MCH)	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	31.0	32.0	31.0	30.0	14.1

State Outcome Measures

SOM 1 - RHD Mortality Rate for ages 5 - 17 years per 10,000.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			29	
Annual Indicator	23.6	28.9	0	
Numerator	49	60	0	
Denominator	20,789	20,789	13,248	
Data Source	RHD registry 2016	RHD Registry	Vital Statistics Death data, US Census Int.	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	31.0	32.0	31.0	30.0	0.0

State Action Plan Table

State Action Plan Table (American Samoa) - Child Health - Entry 1

Priority Need

Promote evidence based developmental screenings for children 0-3 years of age.

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

By 2020, increase the proportion of children (aged 10-35 months) who have been screened for developmental delays, by 10%

Strategies

- Provide training to Providers (WBCs) on Ages and Stages Questionnaires (e.g., ASQ-3; ASQ:SE2).

- Include in MCH mass media campaign compliance with wellness visits for children ages 0-3 years.

- Improve coordination of referral services between medical home and the Helping Hands (early intervention), Helping Babies Hear, MIECHV and Children with Special Health Care Needs by revising SOPs and train staff.

ESMs	Status
ESM 6.1 - Number of Providers utilizing a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months.	Active
ESM 6.2 - Percent of clinical staff trained in the standing operating procedures for referrals to Early intervention and other programs.	Active
ESM 6.3 - Percent of participants in Children’s Oral Health awareness month activities.	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

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

Priority Need

Promote Oral Health for children ages 0 -3 years.

SPM

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

Objectives

By 2020, increase the percent of children ages 1 – 3 years who had a preventive dental visit in the past year by 25%.

Strategies

Promote referral of all children 1 year of age from Well Baby Clinics to Dental Clinics for their first dental visit.

Increase percentage of children ages 1-3 years receiving fluoride varnish at least twice a year.

Provide incentives for children including a toothbrush, floss and toothpaste and oral health pamphlet during Children's Oral Health Month in February.

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

Priority Need

Promote immunization coverage for children ages three.

SPM

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

Objectives

By 2020, increase percent of children ages three are up to date with their routine vaccinations by 5%.

Strategies

Continue to collaborate with the immunization program and promote school outreach activities.

Immunization Program will continue to provide Mass media campaign for immunization compliance.

Train MCH Client Navigators to assist with updating immunization shots in WEB IZ if data entry is behind.

MCH Client Navigators will provide care coordination (reminder calls, transportation, health education).

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

Priority Need

Reduce Rheumatic Fever and Rheumatic Heart Disease.

SPM

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

Objectives

Screen 50% of all children ages 5 – 17 years of age for Rheumatic Fever and Rheumatic Heart Disease by May 30, 2019.

Strategies

Support RHD Prevention Advisory Board to provide review, promote and support program activities, policies, resolutions and accountability.

Provide CME training needs for providers, health educators and partners.

Provide mass media campaign including radio, PSA, social media and outreach health education promotional materials.

Collaborate with agency and community partners and families to implement a heart health month activities including RHD prevention activities.

Build RHD registry database

Revise the RHD Strategic Plan to include progress of systems of care for RHD clients.

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

Priority Need

Reduce Rheumatic Fever and Rheumatic Heart Disease.

SOM

SOM 1 - RHD Mortality Rate for ages 5 - 17 years per 10,000.

Objectives

By May 30, 2019, increase the number of schools receiving RHD screenings by 25%.

Strategies

Continue to collaborate with DOE representative and ensure at least 25% of all public schools are visited in 2018-2019 school year.

Child Health - Annual Report

2018 Accomplishments:

The following are four performance measures that American Samoa selected for Children’s Health domain:

1. **NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.**
2. **SPM 2 - Percent of children, ages 1 through 3 years, who had a preventive dental service in the past year.**
3. **SPM 3 - Percent of children ages 3 who have completed their age-appropriate routine vaccinations.**
4. **SPM 4 - Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.**

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent completed

A total of 49 unduplicated children, ages 9 through 35 months (2 years), whose parents completed a Standardized Developmental Screening tool in the past year were reported by the MCH CSHCN Program (18 children ages 9 through 35 months) and Helping Hands (31 children ages 9 through 35 months). A count from the data in the well-baby clinics could not specify this number as providers are using a self-developed checklist created to screen for developmental delays. This checklist is not AAP approved or standardized. Hence, there may be children with a developmental condition that may not be identified due to this process.

MCH Title V will take a more vigorous approach in assuring children in this age group will receive a developmental screening that is culturally sensitive and appropriate and comprehensive to promote early detection of developmental delays and treatment or referral to appropriate resources and services.

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

SPM 3 - Percent of children, ages 1 through 3 years, who had a preventive dental service in the past year.			
	2016	2017	2018
Annual Indicator	0.9	0.4	1.1
Numerator	29	14	44
Denominator	3200	3200	3861

Dental Services at the community health centers reported that a total of 44 children ages 1 through 3 years received a preventive dental service in 2018. This is 1.1 percent of total population ages 1 through 3 years. Preventive services included a dental check-up, cleaning, topical fluoride varnish treatment and oral hygiene instructions. Only 15 of these children had more than one visit for a dental restoration or dental extraction due to untreated cavities. Despite getting dentists at the Community Health Centers to approve providing preventive dental services for this age-group, there is no care coordination services to ensure that those who are seen at the Well Baby Clinic are also enforced to also get a dental check-up, especially to receive their first dental visit at 12 months of age. The plan to hire a dental assistant to provide at least fluoride varnish, oral hygiene instructions and provide care coordination services to ensure each child gets seen by a dentist by their first birthday did not get

executed because hiring process took more than a year. Despite the low percentage, this SPM has improved slightly compared to year 2016 and 2017.

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

According to the US Census for this age group, a denominator of 957 was reported. Of this group, 576 (60.2%) children ages 3 completed their age-appropriate immunizations. In the past years, the reported percentage was low, this may be attributed to over estimations of the total population of this age group. For this year's reporting, the MCH Title V epidemiologist revised the numbers to reflect a more appropriate count based on the US Census report. This SPM is linked to the NOM 22.1.

It is also imperative to report that from November 2018 to January 2019, ASDOH overall executed an island wide Meningococcal Vaccine campaign to address the low numbers of children ages 13-17 receiving this vaccination. This was initiated by the Director of Health after notification of children dying from the neighboring Samoa Islands due to meningococcal infection.

Considering the frequent travelling of people between the two Samoa Island countries, it was essential to address this issue and not wait for American Samoa to deal with an actual case. Nonetheless, the territory reported one case of an infant who travelled with parents from New Zealand to American Samoa to visit families. The infant became ill and was tested positive for meningococcal. All necessary precautions were exercised, the child's condition improved, and the territory was able to prevent a possible outbreak from this contagious disease. MCH Title V personnel was in the forefront of this campaign and contributed time and resources to this effort.

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

A sonography training was initiated in February 2018, inviting 2 US certified sonographers who train internationally to come to American Samoa and train individuals who can learn basic echo protocols to screen for acute rheumatic fever and rheumatic heart disease among the school-aged children population. Training was conducted over a period of 2 weeks which included theory and practical sessions. Local personnel who were trained were selected from the LBJ Hospital and the local health department. All seven trainees received a certificate of completion and encouragement to continue practicing their learned skills.

Following this training, a central echo clinic was open to the public where parents can bring their child in for an echo, providers from both LBJ and DOH can refer their suspected cases for a screening. This opportunity was provided at no charge to the public, and offered to any age group that needed this service. Echo images were then uploaded to a cloud-based HIPAA compliant system, in which cardiologists from off-island could view and provide a final diagnosis. Report would then be forwarded to patient or client for management by their primary care provider.

At present time, only two of the trainees are consistently practicing their echo skills, while others have had difficulty continuing this skill due to their previous job obligations. MCH Title V and the RHD program will have to re-examine this issue and strategize on how to support an independent team of echo technicians who will go out to the schools and screen children throughout the school year.

To date, more than 100 children and adults have come through this clinic to be screened, with echo images upload for interpretation. Through a recent CDC Epi Aid project, RHD prevalence was noted at 13.5 per 1000 for children ages 5-17. This is a collective number derived from databases maintained by DOH, OHSU, and BYU, as well as the Electronic Health Records managed by LBJ between the years 2016-2018. This continues to confirm that RHD is a significant problem among children of American Samoa and should be prioritized in resources and services.

Strengths

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

- CHC's Well Baby Clinic is an appropriate venue to implement the screening tool
- Clinicians are aware of the importance of this tool
- Care Coordinators can assist with translating and filling out of parent questionnaires.
- Helping Hands PT Dr. Joyce Ursulino is willing to provide the ASQ training once the tools are purchased.

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

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

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

- Immunization Program provides technical assistance for clinician and nurses, provide vaccines as well as responsible for updating the database WeblZ.
- MCH Epi provides surveillance and reporting to key leaders and stakeholders.
- Headstart ECE collaborates with DOH and enforces the completion of all needed vaccines prior to entering preschool.

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

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

Challenges

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

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

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

- MCH Dental Assistant position remained vacant until March 2019.
- Inadequate space at the Tafuna dental clinic to accommodate four dentists at a time. There are only three dental chairs and barely any other space for a fourth dentist to utilize.
- CHC purchasing of dental supplies takes a long time. MCH has been providing fluoride varnish and dental sealants in the last three years.

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

- Families wait until child is ready to be registered for preschool then bring their children to update their vaccinations. It may take more than one visit to complete them.
- None of the CHC WBCs have appropriate refrigerators. Immunization Program staff delivers every morning and pick-up leftovers after work daily.

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

- Need a full-time echo technician dedicated to RHD screening. Right now, trained personnel have other commitments and only screen when they are available.
- Need commitment from the advisory board to meet more frequently.
- Insufficient program staff. Only the program coordinator and an administrative assistant.
- Need a full-time nurse who can also be a case manager and care-coordinator.

Child Health - Application Year

Current activities for 2019

Nursing Division, Immunization Program, and MCH Title V continue to work collaboratively to address immunization concerns for the territory, particularly during potential outbreaks based on geographical surveillance. ASDOH leaders are consistently updated and well informed of such issues to provide guidance on best practices and approaches necessary to prevent local outbreaks and epidemics.

- Outreaches to private and public schools are continued with ASDOH placing substantial emphasis on students being fully immunized prior to school entrance.
- Media coverage throughout the year on radio, newspaper, and local TV station as well as social media to promote age-appropriate immunizations and well child services available at the health centers.
- Training on the Ages & Stages Questionnaire (ASQ) screening tool was provided by the Early Intervention Program Physical Therapist to the staff members of the Title V and Zika MCH Programs.
- Zika Navigators have worked collaboratively with the Immunization staff to assist families who need to get updated vaccinations for their children by providing support in terms of transportation to and from well-baby clinics, re-appointments, and support for social issues that may hinder a child from receiving updated immunizations.
- Improve coordination of referral services between the client's medical home and the DOH programs that serve children, to include Helping Hands (early intervention), Helping Babies Hear, MIECHV, and Children with Special Health Care Needs.
- Title V has recently hired a certified dental assistant to provide fluoride varnish to children at the well-baby clinics in Tafuna and Fagaalu. Children are provided also with incentives such as a toothbrush, floss and toothpaste and oral health pamphlet

Future Plans 2020

- Plan & Implement training for providers at the well-baby clinics to utilize standardized screening tools to detect developmental delays among children population so early detection and treatment or necessary services are provided at most appropriate times.
- Revive relationship with the American Academic of Pediatrics (AAP) to provide training on Bright Futures Curriculum to benefit the overall health of the children population in the territory.
- Promote referral of all children 1 year of age from CHC WBCs to dental clinics for their first dental visit
- Increase percentage of children ages 1-3 years receiving fluoride varnish at least twice a year.
- Continue to collaborate with the immunization program and promote school outreach activities.
- Title V and Immunization Program will collaborate to continue to provide Mass media campaign for immunization compliance.
- MCH Client Navigators to assist with updating immunization shots in WEB IZ if data entry is behind.
- MCH Client Navigators will continue provide care coordination services to all Title V & Zika clients (reminder calls, transportation, health education).
- Support RHD Prevention Advisory Board to provide review, promote and support program activities, policies, resolutions and accountability.
- Continue to provide and support CME training needs for providers, health educators and partners.

- Collaborate with agency and community partners and families to implement a heart health month (September) activities including RHD prevention activities.
- Build and maintain a comprehensive RHD registry database for all health entities to access and use in the territory.
- Revise the RHD Strategic Plan to include progress of systems of care for RHD clients.
- Provide care coordination for children to ensure compliance with bicillin shot appointments, including follow up and reminder calls.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	Data Not Available or Not Reportable	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	Data Not Available or Not Reportable	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	Data Not Available or Not Reportable	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	16.3 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2013	41.5 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	38.4	NPM 10

National Performance Measures

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			60
Annual Indicator	59.2	39.6	39.8
Numerator	4,561	5,049	2,555
Denominator	7,710	12,758	6,414
Data Source	AS CHC and Immunization Program	AS CHC and Immunization Program	Immunization Office Registry Web IZ US Census Int.
Data Source Year	2016	2016	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	61.0	62.0	63.0	64.0	65.0	65.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of schools covered by Immunization School Outreach Program.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		5	79	
Annual Indicator	54.8	78.6	95.6	
Numerator	23	33	43	
Denominator	42	42	45	
Data Source	ASIP	ASIP	Immunization Office and MCH Epidemiologist	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	81.0	82.0	83.0	84.0	90.0

ESM 10.2 - Number of high schools covered by Immunization School Outreach Program.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	95.0	96.0	97.0	99.0	100.0	

State Performance Measures

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			29	
Annual Indicator	23.6	28.9	15.1	
Numerator	49	60	20	
Denominator	20,789	20,789	13,248	
Data Source	RHD registry 2016	RHD registry	MCH RHD Registry (BYU, OSHU, MCH)	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	31.0	32.0	31.0	30.0	14.1

State Action Plan Table

State Action Plan Table (American Samoa) - Adolescent Health - Entry 1

Priority Need

Promote preventive medical visits for adolescents ages 12-17.

NPM

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

Objectives

By 2020, increase percent of adolescents ages 12 – 14 years (6-8 grade students) with HPV vaccination coverage to 76%.

By 2020, decrease the percent of teenage pregnancy by 5%.

By May 30, 2019, in a collaborative effort with other agencies and private sectors to establish an Adolescent Health Advisory Group/Taskforce.

Strategies

Promote mass media campaign for HPV shots.

Immunization Program continue to provide school-based clinics to promote accessibility and utilization of services.

MCH Client Navigators will provide care coordination for YSHCN (reminder calls, transportation).

Continue to collaborate with Intersections Inc. to promote their peer mentoring program for middle schools and high schools.

Provide mass media campaign for promoting healthy lifestyle choices to prevent teenage pregnancy.

Collaborate with Prenatal providers to continue to promote family planning awareness and contraceptives.

Establish an Adolescent Health Advisory Board/Taskforce.

ESMs

Status

ESM 10.1 - Percent of schools covered by Immunization School Outreach Program.

Active

ESM 10.2 - Number of high schools covered by Immunization School Outreach Program.

Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Adolescent Health - Annual Report

Last Year (2018) Accomplishments

By 2020, increase percent of adolescents ages 12 – 14 years (6-8 grade students) with HPV vaccination coverage to 76%.

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine.				
	2015	2016	2017	2018
Annual Indicator	71.2	72.1	80.3	77.2
Numerator	3737	3841	4280	4099
Denominator	5248	5328	5328	5309

Adolescent Health was monitored under various programs who cater specifically towards this age group 13 through 17 years. Such programs include the Community Health Centers, the Immunization Program, and the Intersections Program which serves adolescents and children through community service projects, peer learning, and education.

Adolescents seek health services by coming to the Well Child Clinic (Pediatric) at the community health centers for their HPV vaccines or a physical exam to transfer to college or play a sport. A **77.2%** of teens visited the clinic for a preventive medical visit including getting their HPV vaccines done. The Immunization Program continues to visit schools, update students' immunization information and given reminders to update their shots if needed. The data trend above is showing some promising results especially with the improving rate of 6% increase since 2015.

Objective 8.2. By 2020, decrease the percent of teenage pregnancy by 5%.

Teenage Pregnancy continues to decline, dropping tremendously from 37.9 per 1,000 females ages 15 – 19 years in 2017 to **22.5 per 1,000 in 2018**. This is a total of 54 teen births. A further breakdown of this number shows 13 cases were between the ages of 15-17 years and 41 cases were between the ages of 18-19 years. This rate is very low compared to past years and actually closer to the rate of 18.8 per 1,000 reported by CDC on a national average in 2017. Reasons for the declines are not totally clear, but evidence suggests these declines are due to more teens abstaining from sexual activity, more teens who are sexually active using birth control than in previous years. Other programs which promote measures to prevent teenage pregnancy includes the Intersections Inc, STD Program and Family Planning.

ASMCH Title V and Intersections Inc. have an existing cooperative agreement that Intersections Inc. will promote prevention of risky health behaviors such as bullying, substance abuse, violence and teenage pregnancy in schools. More than 800 students participated in 2018.

Strengths

- The opportunity to update immunization shots such as HPV, booster shots and meningococcal vaccines provides an opportunity for the adolescents to also get an annual physical screening.
- The Immunization Program, Department of Education and the Community Health Centers collaborative efforts ensures that preventive medical visits for this age-group is promoted annually.
- Other Non-Profit Organizations such as Intersections Inc, Alliance for Domestic Violence and faith-based organizations fully support preventive health efforts for teens.
- Availability of abstinence and sex education in schools and the Ta'iala Peer Leaders Initiative provides opportunities to promote healthy behaviors and preventing other risky behaviors such as violence and substance abuse, and bullying.

Challenges

- No specific Adolescent Health Clinics. Females are encouraged to seek reproductive health services via the Women's Health Clinic afterhours at CHC and Family Planning at LBJ.
- Annual physical screenings are not routinely done at the Well Child Clinic unless they are coming to update immunization shots. Teens have to compete with adults at the Primary Care Clinics for an annual physical

screening. They are encouraged to get another the following year but yet are not given appointments to return. There is lack of promotional activities to support continuum of care such as routine annual physical screening.

Current activities for 2019

Objective 8.1: By 2020, increase percent of adolescents ages 12 – 14 years (6-8 grade students) with HPV vaccination coverage to 76%.

- The Immunization Program continues to implement a mass media campaign promoting updates of children's vaccinations including HPV.
- The MCH Epi works closely with the Immunization Program to provide surveillance and monthly updates to the DOH senior leaders.
- The YSHCN client navigator, Florence Tauaefa provide appointment reminders and transportation for YSHCN who needs to update their vaccinations and annual physical screenings.
- The Immunization Program provides school visits to provide update reminders newsletters for students to take home to parents.

Objective 8.2. By 2020, decrease the percent of teenage pregnancy by 5%.

- Continue to collaborate with Intersections Inc. to promote their peer-mentoring program for middle schools and high schools.
- Provide mass media campaign for promoting healthy lifestyle choices to prevent teenage pregnancy.
- Collaborate with Prenatal providers to continue to promote family planning awareness and contraceptives.

Objective 8.3: Formulate an advisory group/taskforce represented of various agencies and programs focused on adolescent health.

- The ASMCH Title V and currently planning with the Intersections Inc. to initiate an Adolescent Health Advisory Group to assist with formulating a Territorial Health Plan for this domain as well as assisting in completing the Five-Year Needs Assessment for this population.

Future Plans 2020

By 2020, increase percent of adolescents ages 12 – 14 years (6-8 grade students) with HPV vaccination coverage to 76%.

8.1.1 Promote mass media campaign for HPV shots.

8.1.2. Immunization Program continues to provide school-based clinics to promote accessibility and utilization of services.

8.1.3. MCH Client Navigators will provide care coordination for YSHCN (reminder calls, transportation).

Objective 8.2. By 2020, decrease the percent of teenage pregnancy by 5%.

8.2.1 Continue to collaborate with Intersections Inc. to promote their peer-mentoring program for middle schools and high schools.

8.2.2. Provide mass media campaign for promoting healthy lifestyle choices to prevent teenage pregnancy.

8.2.3. Collaborate with Prenatal providers to continue to promote family planning awareness and contraceptives.

Objective 8.3: Formulate an advisory group/taskforce represented of various agencies and programs focused on adolescent health.

Children with Special Health Care Needs

Linked National Outcome Measures

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

National Performance Measures

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

NPM 11 - Children with Special Health Care Needs

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

State Provided Data			
	2016	2017	2018
Annual Objective			72
Annual Indicator	71.8	74.3	43.3
Numerator	18,366	19,099	7,815
Denominator	25,579	25,722	18,063
Data Source	ASCHC and Immunization Program	ASCHC and Immunization Program	MCH CSHCN, Part C, CHC UDS Report
Data Source Year	2016	2016	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	72.5	73.0	73.5	74.0	74.5	50.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of CSHCN families who received care coordination services from CSHCN staff in the past year.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		15	59	
Annual Indicator	80	58.2	48.6	
Numerator	88	64	51	
Denominator	110	110	105	
Data Source	2016	2017	2018	
Data Source Year	CSHCN	CSHCN	CSHCN	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	60.0	61.0	62.0	63.0	64.0	60.0

State Performance Measures

SPM 5 - Percent of families of children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV who reports they are satisfied with their care coordination services.

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	25.0	30.0	35.0	40.0	69.0

State Action Plan Table

State Action Plan Table (American Samoa) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve system of care for CYSHCN..

NPM

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

Objectives

BY 2020, Increase family involvement in all decision making for CSHCN health care management, to 50%.
 By 2020, increase the proportion of families who receive care coordination support through cross-system collaboration by 25%.

Strategies

Provide care coordination for families of Children and Youth with Special Health Care Needs to improve accessibility and utilization of medical homes.

Engage LBJ Pediatricians and other specialists with Well Baby Clinic providers in collaborative coordination for CSHCN.

Implement communication and referral protocols for CSHCN Care Coordinators (Client Navigators) and providers.

Collaborate with the Parent Network for Children with Special Needs to implement workshop training for families.

Provide annual updates on care coordination services, challenges and success stories during CME sessions with medical staff.

Host webinars and online trainings for health providers on caring for CSHCN, adapting from the Caring for People with Disabilities course.

Incorporate family-provider (parent/guardian, primary provider, care coordinator, nurse practitioner) health care plan (HCP) meetings.

Revise SOPs to reflect recommendations.

ESMs	Status
ESM 11.1 - Percent of CSHCN families who received care coordination services from CSHCN staff in the past year.	Active

NOMs

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

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Priority Need

Promote care coordination services for children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV.

SPM

SPM 5 - Percent of families of children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV who reports they are satisfied with their care coordination services.

Objectives

By 2020, Ensure that at least 60% of all infants born with Congenital Zika or to pregnant women diagnosed with Zika utilized a medical home.

Strategies

Provide care coordination for all children diagnosed with Congenital Zika or born to pregnant women diagnosed with Zika.

Host webinars and online trainings for health providers on caring for Zika clients.

Increase media campaign including social media to improve awareness and utilization of services.

Revise current SOP for Zika Outbreak Response Manual to reflect planned activities and train MCH staff to provide services accordingly.

Last Year (2018) Accomplishments

OBJECTIVE 9.2: 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.

Medical home utilization continues to be the goal for CSHCN for every reporting year, advocating to families and guardians of CYSHCN to access and utilize the community health centers or the local hospital. With utilization of available services, systems can be evaluated and improved to meet the specific needs of this population.

During 2018, the CYSHCN program was able to provide care coordination to majority of clients that were recruited into the program. These clients received components of a well-functioning system, to include family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition. About 73.9% of this population was served in 2018. Other families and clients either relocated without prior notice, or denied participating in the program.

Strengths

- Client Navigator for CYSHCN is working alongside the Zika Client Navigators, share best practices, resources, information and ideas to improve services
- Client Navigator assisted with operating the Zika vehicles since the ZCNs were unable to have official license to drive government vehicles until they worked longer than 6 months in DOH.
- CSHCN Navigator coordinated primary care visits for CYSHCN clients at each of the district health centers, collaborating with providers and nurses on appropriate times/dates.
- Transportation available to assist clients who may need a ride to and from the clinic.
- Shriners Clinic twice annually from Hawaii provide pediatric orthopedic services for CSHCN

Challenges

Hiring process for government workforce is very extensive, may take up to six or more months to acquire another navigator for the CYSHCN Program

- Providers may not be comfortable with special needs population due to lack of training on specialty care.
- Lack of utilization of the Family/Patient Centered Care Model by providers to serve individuals with special needs and their families.
- Limited resources and specialty care for CYSHCN (PT, OT, Speech Therapy, Neurology, etc.)
- Limited advocacy from families of CYSHCN due to lack of understanding pertaining to rights and services that are beneficial to this population.
- There is no current count of CYSHCN island wide, so it is difficult to develop plans that can service and support this group. The count for children in the school system with an Individualized Education Plan (IEP) includes children who are identified to have a learning disability and not necessarily a developmental disability. Therefore, this number could be an overestimate of the CYSCHN population.
- Interagency on disabilities need to be restored and strengthened, to best advocate for people with disabilities, including children.

Children with Special Health Care Needs - Application Year

Current Activities (2019)

- Newly hired Client Navigator has managed to accommodate about 70% of the clientele for CYSHCN. Providing care coordination to families of CYSHCN and assisting with specific social needs however possible. Client Navigator is getting trained on the job, but has already demonstrated great skills in connecting to families and navigating the system to engage providers and families in optimizing health services for this population.
- CYSHCN is collaborating closely with the newly established Family to Family Health Information Center, to increase parent and family participation with the center and to determine advocacy activities that would best fit the needs of families and their CYSHCN.
- CYSHCN are benefiting from screening opportunities through the Zika Program. Screenings for vision and hearing, as well as dental are offered to CYSHCN. Such screenings are accessible at no cost to the families with free transportation to access these clinics during the weekends or after hours.
- CYSHCN are continually partnering with the Parents Network of children with special needs during the summer months to support a one-week summer camp catered for this specific population. Children with special needs of all ages are encouraged to come out and join in community activities that are designed specifically for them.
- CYSHCN continues to engage nonprofit organizations and local businesses to raise more awareness on the special needs population and its contribution to society. With very little resources available for these children on island, this program reaches out to the community for support and commitment.
- CYSHCN continues to work closely with Medicaid and the LBJ Hospital to determine what can be sponsored by funding that is available towards durable medical equipment (DME) that is much needed by many of the children with special needs, but are too expensive to be purchased by individual families. CYSHCN Navigator is key in this process, to assure that specific health needs are met and supported, and resources are identified with payment guaranteed.

Future Plans (2020)

- Hire additional CYSHCN Navigator or Case Manager for this program to help manage cases thoroughly
- Incorporate family-provider (parent/guardian, primary provider, care coordinator, nurse practitioner) **health care plan** (HCP).
- Create Standard Operating Procedures (SOPs) on how to implement HCPs and engage families/parents to promote Family/Patient centered care model.
- Offer trainings for providers on Family/Patient Centered Care.
- Continue to provide care coordination for families of Children and Youth with Special Health Care Needs to improve accessibility and utilization of medical homes.
- Engage LBJ Pediatricians and other specialists with WBC providers in collaborative coordination for CYSHCN. Also will need to improve communication and referral protocols for CYSHCN Care Coordinators (Client Navigators) and providers.
- Collaborate with the Family to Family Health Information Center to implement at least three community outreach mini-workshops in the west, central and east districts for families and providers to share services, challenges and success stories.
- Provide annual updates on care coordination services, challenges and success stories during CME sessions with medical staff.
- Mass media campaigns to promote utilization of clinics for medical care.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Building - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

Public Input

The American Samoa MCH Title V engaged an array of stakeholders, including parents and consumers, prior to and during the Title V application process. In 2015, ASMCH completed a statewide five-year needs assessment to identify strategic issues and priority needs to drive creation of the 2016-2020 state action plan as required by Title V. When determining the process to be used, the Needs Assessment Planning Committee prioritized the need to engage a diverse group of stakeholders to assess both needs and system strengths and capacity. As a result, the needs assessment workgroups (which reflected the six original population health domains) included state and local MCH staff, state and local MCH system partners, parent consultants, consumers, and partners with expertise in health equity. Their input and experience directly shaped the issues and priority needs considered and included in American Samoa's five-year application.

Public input was obtained through a stakeholder meeting in 2017 and advisory board meetings conducted throughout 2018. In July 2017, an MCH stakeholders meeting was called for MCH partners to view priorities and measures in place for Title V. Twenty partners participated in this 2.5 hours meeting. In August 2017, another MCH Stakeholders meeting was accomplished to initiate a Strategic Plan for the RHD Prevention and Control Program. Majority of invited representatives from core agencies attended and are listed in the table below:

1. Dr. Annie Fuavai, Deputy CMO	LBJ Hospital
2. Dr. Nestor Devesi	LBJ Chief of Pediatrics
3. Dr. Amelita Mejia	LBJ Pediatrics
4. Ray Tulaofono	LBJ Chief of MIS
5. Magdalene Augafa	DOE Office of Science and Health Curriculum
6. Saulelia Wilson Sualevai	USDA
7. Yolanda Masunu	Immunization Program
8. Leiema Hunt	Preventive and Health Services (CDC funded)
9. Margaret Sesepasara	MCH Title V Director
10. Tele Hill	Family Nurse Practitioner

11. Dr. Fuimaono	ASCHC Clinical Director
12. Maria Conrad	Primary Health RN
13. House Rep. Samuel Meleisea	House Representative, Tualauta County
14. House Rep. Vui Florence Saulo	House Representative, Tualauta County
15. House Rep. Faufano Autele	House Representative, Manu'a County
16. Muaiao Moliga	RHD Parent
17. Stephen Orton	MCH Workforce Development, AMCHP
18. Motusa Tuileama Nua	ASDOH Director
19. Dr. Christina Pola	Headstart Dentist
20. Dr. Leute Leota	LBJ Chief of Dental Services

In 2018, a draft of the Title V FY 2019 application/FY 2017 annual report send out via email to approximately 20 advisory group members, nonprofit partners, advocacy groups, other state programs, parents and consumers. Public input was reviewed and shared with the Title V steering committee for review and consideration prior to the July 2018 submission date. Six partners had responded back to the email notifications via telephone calls, emails and face-to-face verbal conversations. Data were then reviewed and adjusted as well as the FY 2019 action plan, accordingly.

For this application cycle, the executive summary and budget of the Title V FY 2020 application/FY 2018 annual report will be disseminated to key stakeholders and consumers for review and comment. Public input will also be invited through notification to approximately 39 advisory groups, community-based partners, nonprofit partners, advocacy groups and other government programs. Public input will be reviewed and shared with the Title V steering committee for review and consideration prior to the July 2019 submission date. The number and nature of public comments received, and how they were addressed, will be included in the final grant submission. If any other feedbacks are received after submission on July 15, they will still be taken into consideration and once TVIS reopen after the AS Block Grant Review on August 27, adjustments will be made if the MCH steering committee see a positive impact if added.

Below are targeted key stakeholders participating in the public input:

1. Ken Kuaea, Community Health Centers Executive Director
2. Luana Leiato, Breastfeeding Coordinator, WIC
3. Dr. Ianeta Timoteo, LBJ Hospital Family Planning (Title X)
4. Jacki Tulafono, NCD Program Coordinator
5. Farrah Lesa, Tobacco and Diabetes Program Coordinator
6. Moira Wright, Breast and Cervical Cancer Screening Program
7. Rosita Alailima-Utu, Parent
8. Sandra Scanlan, Children with Special Needs Network
9. Dr. Bethel Howard, LBJ OBGYN Chief
10. Ina Sagaga, Communicable Disease Programs (STD/HIV/TB)
11. Judy Matautia, Alliance Against Domestic and Sexual Violence
12. Mayper Ledua, Supervisor Nurse, LBJ Medical Center's Nursery
13. Merenaite Liua, Aiga Manua Maternal Infant Early Childhood Home Visiting (MIECHV) Program
14. Dr. Talifa Talifa Jr, CHC Chief Dental Services
15. Bethany Toelupe, Helping Babies Hear Program Coordinator
16. Philo Jennings, DOE Elementary Division Deputy Director
17. Mllaneta Tinitali, Early Childhood Education (Head Start)
18. Dr. Maria Gayapa, LBJ Pediatrician
19. Dr. Mirella Chipongian, CHC Prenatal Physician
20. Sapi Galeai, School Lunch
21. Travis Flemming, Land Grant
22. Child Care Services (Early Head Start)
23. Li'a Seiuli, Director, Intersections Inc.
24. David Bird, Department of Public Safety
25. Father Vaiula, Aua Catholic Church
26. Faauai Vaitautolo, Deputy Director, DOE Secondary Division
27. Lupelele Sunia, Assistant Director, DHSS Mental Health
28. Siitia Lemusu, CHC Behavioral Health Program Coordinator
29. Dr. Faiese Talafu, CHC Pediatrician
30. Roseanne Filise, Helping Hands Program Coordinator
31. Vai Fuata, Immunization Program Coordinator
32. Teresa Atuatasi, SPED Director
33. Peter Tinitali, Vocational Rehabilitation Director
34. Tafa Tupuola, UCEDD Director
35. Norma Smith, DD Council Assistant Director
36. Leone Ripley, Special Olympics Secretary
37. Dr. Celestine Faumuina, Assistant Director, Child Protective Services
38. House Representative Vesi Fautanu, Chairman of Health Committee
39. Sandra King Young, American Samoa CMS Director

After the application has been submitted, ASMCH will continue to work with entities representing advocates, advisory bodies, providers and consumers to receive input on the programs, policies, reports and plans included in the Title V application. For example, the Children's Special Health Care Needs (CSHCS) Division routinely works

with the Parent Network for children with special needs, Helping Hands Early Intervention, Helping Babies Hear and SPED. All these partners provide information and support to families and input on CSHCN program operations. By receiving ongoing feedback and recommendations will refine current policies and SOPs and promotes awareness to assure that services reflect the voices of individuals with special health care needs and their families.

It is critical to also report back to all represented entities to maintain and strengthen existing relationships that will definitely come in handy as ASMCH continues to execute the Five-Year Needs Assessment. Engaging families and key stakeholders in the entire process of the Needs Assessment will provide favorable outcomes and a robust Strategic Plan to target American Samoa's identified priorities needs.

III.G. Technical Assistance

FY 2018

In FY 2018 and during completion of the grant application, potential areas of training and/or technical assistance were identified. These areas include:

1. Best practices and tools related to American Samoa's ongoing needs assessment priorities, specifically performance monitoring for National Performance Measures (NPMs) and Evidence-based or –informed Strategy Measures (ESMs);
2. Support of local public health partners in implementing new requirements and priorities as they relate to Title V
3. Sharing of best practices and other peer learning opportunities (e.g., within USAPI jurisdictions and other Region IX states) in shared NPMs and SPMs
4. Ongoing learning opportunities and technical assistance related to identification, refinement, and assessment of ESMs.
5. Care Coordination learning opportunities to improve service capacity for Children with Special Health Care Need

Some of these identified needs were met by training and professional development opportunities provided by HRSA and AMCHP throughout the year. In particular, American Samoa attended the Workforce Development summer institute in July 2018, in Arizona. A team of four comprising of MCH Title V staff, parent and advisory board member worked on identifying next steps to better improve the current strategic plan and school screenings for RHD.

FY2019

Any training or technical assistance provided by HRSA or AMCHP—especially in relation to ESMs, NPMs, TVIS, and other Title V priorities or requirements—is currently being shared with relevant programs and key stakeholders. A team of four MCH Title V staff consisted of the MCH Program Coordinator, Nurse Practitioner, Epidemiologist and the RHD/CSHCN Program Coordinator (also the Family-to-Family Support Program Director) attended the Honolulu MCH Federal and Territorial Partnership TA meeting back in April 23-26. The team had the opportunity to learn best practice in terms of writing and finalizing ESMs; successes and lessons learned in planning and implementing the Title V Five-Year Needs Assessment; Oral Health integration into the Needs Assessment, Rheumatic Heart Disease and the public health approaches to advance primary prevention, screening and treatment; family and stakeholder engagement in the Needs Assessment process; and other Title V process and reporting requirements for the 2020 application.

American Samoa agrees with the rest of their US affiliated neighbors in the blue Pacific that these TA meetings greatly benefits and positively impacts each of their MCH Programs. Spring TAs empowers the current MCH workforce, builds skills and competencies that would not have been easily achieved if these TA meetings were not available in these avenues. Having the opportunity to learn from other island countries who may have similar cultures, values, geographical locations, demographics, and challenges, inspires and keeps them motivated.

This year, a team of CDC Epi Aids were here in American Samoa in the month of June, 2019, to provide technical assistance with 1) estimating prevalence and incidence, 2) establishing a working registry, and 3) referral procedures for a possible RHD clinic. Existing partnerships with both CHCs and LBJ clinicians, consumers and the community continue to be strengthened and empowered by the end results of these technical assistants.

2020 Technical Assistance Requests:

1. Executing Stakeholders' engagement and maintaining their involvement in all phases of the 5 Year Needs Assessment until completion.
2. Establish a 5 Year Territorial Strategic Plan for Women's Health
3. Sharing of best practices and other peer learning opportunities (e.g., within USAPI jurisdictions and other Region IX states) in shared NPMs and SPMs
4. Ongoing learning opportunities and technical assistance related to identification, refinement, and assessment of ESMs.
5. Care Coordination learning opportunities to improve service capacity for Children with Special Health Care Need

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [AS_TitleV_Medicaid_IAA.pdf](#)

V. Supporting Documents

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

Supporting Document #01 - [Acronyms.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [ASMCH Org Chart_7_16_18.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: American Samoa

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 485,500	
A. Preventive and Primary Care for Children	\$ 145,900	(30%)
B. Children with Special Health Care Needs	\$ 160,000	(32.9%)
C. Title V Administrative Costs	\$ 0	(%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 305,900	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 364,125	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 364,125	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 318,604		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 849,625	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 400,000	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 1,249,625	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Zika Maternal and Child Health Services Program	\$ 350,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 50,000

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 485,820		\$ 490,711	
A. Preventive and Primary Care for Children	\$ 200,000	(41.2%)	\$ 150,000	(30.5%)
B. Children with Special Health Care Needs	\$ 200,000	(41.2%)	\$ 160,374	(32.6%)
C. Title V Administrative Costs	\$ 0	(%)	\$ 0	(%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 400,000		\$ 310,374	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 0		\$ 368,100	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 400,000		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 400,000		\$ 368,100	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 318,604				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 885,820		\$ 858,811	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 595,374		\$ 211,805	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 1,481,194		\$ 1,070,616	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 35,287
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Zika Maternal and Child Health Services Program	\$ 500,000	\$ 176,518

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children
	Fiscal Year:	2020
	Column Name:	Application Budgeted
	Field Note:	Due to the needs assessment due in FY 2020, AS MCH is allocating more funds to such as data capacity, consultation contractual services and improvement of current public health systems.
2.	Field Name:	Federal Allocation, B. Children with Special Health Care Needs
	Fiscal Year:	2020
	Column Name:	Application Budgeted
	Field Note:	Due to the needs assessment due in FY 2020, AS MCH is allocating more funds to such as data capacity, consultation contractual services and improvement of current public health systems.
3.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2020
	Column Name:	Application Budgeted
	Field Note:	Total amount budget is less than total amount expended in FY 18
4.	Field Name:	4. LOCAL MCH FUNDS
	Fiscal Year:	2020
	Column Name:	Application Budgeted
	Field Note:	Please refer tp State Match

Data Alerts:

-
- The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
 - The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
 - The value in Line 3, State MCH Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
 - The value in Line 4, Local MCH Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

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

State: American Samoa

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 30,000	\$ 57,710
2. Infants < 1 year	\$ 40,000	\$ 30,000
3. Children 1 through 21 Years	\$ 145,900	\$ 150,000
4. CSHCN	\$ 160,000	\$ 160,374
5. All Others	\$ 109,600	\$ 92,627
Federal Total of Individuals Served	\$ 485,500	\$ 490,711

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 22,500	\$ 43,282
2. Infants < 1 year	\$ 30,000	\$ 22,500
3. Children 1 through 21 Years	\$ 109,425	\$ 112,500
4. CSHCN	\$ 120,000	\$ 120,281
5. All Others	\$ 82,200	\$ 69,470
Non-Federal Total of Individuals Served	\$ 364,125	\$ 368,033
Federal State MCH Block Grant Partnership Total	\$ 849,625	\$ 858,744

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: American Samoa

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 235,900	\$ 207,374
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 30,000	\$ 47,000
B. Preventive and Primary Care Services for Children	\$ 45,900	\$ 100,000
C. Services for CSHCN	\$ 160,000	\$ 60,374
2. Enabling Services	\$ 140,000	\$ 190,710
3. Public Health Services and Systems	\$ 109,600	\$ 92,627
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 207,374
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Direct Services Line 4 Expended Total		\$ 207,374
Federal Total	\$ 485,500	\$ 490,711

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 176,675	\$ 152,531
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 22,250	\$ 35,250
B. Preventive and Primary Care Services for Children	\$ 34,425	\$ 75,000
C. Services for CSHCN	\$ 120,000	\$ 42,281
2. Enabling Services	\$ 105,000	\$ 143,033
3. Public Health Services and Systems	\$ 82,200	\$ 69,470
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 152,531
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Direct Services Line 4 Expended Total		\$ 152,531
Non-Federal Total	\$ 363,875	\$ 365,034

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: 931

Data Source Year: 2018

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	911 (97.9%)	14	2	2 (100.0%)

Program Name(s)
Hearing Loss

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Rheumatic Heart Screening	928	25	20	20
Group B Strep Screening	266	210	105	105

4. Long-Term Follow-Up

Hearing screening is a routine and required screening for all newborns born in the hospital, and is performed by the Helping Babies Hear (HBH) Program. The initial inpatient hearing screening is performed before newborns are discharged, and may range from 24 to 48 hours after birth or more depending on whether the newborn is admitted to the NICU for complications. If a newborn does not pass the initial inpatient hearing screening, they are referred to the HBH Program and are scheduled for another hearing screening within 2 weeks from initial inpatient screening. If a newborn again does not pass the second outpatient hearing screening, the HBH Program will refer the newborn to an audiologist or specialist within 6 months to confirm if the newborn is diagnosed with a hearing loss.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	Field Name:	Total Births by Occurrence
	Fiscal Year:	2018
	Column Name:	Total Births by Occurrence Notes
	Field Note:	<p>The total births by occurrence was 931, which includes both live births, and stillbirths. There was a total of 918 live births, and 13 stillbirths from January to December 2018. Live births include infants that were live at birth, but were later deceased after the date of birth. A stillbirth was defined as a fetus who was delivered without life and a gestational age of 28 weeks or more.</p> <p>A total of 926 births occurred in the hospital and 5 births occurred outside of the hospital (i.e. home delivery or enroute to the hospital). All home births were live births and a total of 13 stillbirths (28 weeks gestation or more) were recorded in the hospital.</p>
2.	Field Name:	Data Source Year
	Fiscal Year:	2018
	Column Name:	Data Source Year Notes
	Field Note:	<p>2018 is defined as a time period beginning from January 1, 2018 to December 31, 2018.</p>
3.	Field Name:	Core RUSP Conditions - Receiving At Least One Screen
	Fiscal Year:	2018
	Column Name:	Core RUSP Conditions
	Field Note:	<p>A total of 911 infants received inpatient hearing screening before they were discharged from the hospital. Hearing screening occurred between 24 to 48 hours after birth. However, screening for infants who had complications or were admitted to the NICU exceeded the 24 to 48 hour time period.</p>
4.	Field Name:	Core RUSP Conditions - Positive Screen
	Fiscal Year:	2018
	Column Name:	Core RUSP Conditions
	Field Note:	<p>Of the 911 infants who underwent hearing screening, 14 infants did not pass the initial inpatient hearing screening. The 14 infants who did not pass inpatient screening were referred and were scheduled for another hearing screening within 2 weeks from initial inpatient screening. The 14 referral infants had the following risk factors: a Zika positive mother (history prior to 2018) , premature infant, admitted to the NICU for more than 5 days.</p>

5.	Field Name:	Core RUSP Conditions - Confirmed Cases
	Fiscal Year:	2018
	Column Name:	Core RUSP Conditions
	Field Note:	Of the 14 infants who were scheduled for outpatient rescreening 2 weeks or more after birth, 7 infants completed the outpatient rescreening. The other 7 infants did not complete outpatient rescreening, 4 infants were deceased by the time of outpatient rescreening, 2 infants moved off island, and the 1 infant's parents declined screening. Of the 7 infants who completed rescreening, 4 infants passed the outpatient rescreening (2 weeks) while the other 3 infants were referred for rescreening at 6 months. The 3 referred infants completed rescreening at 6 months and 2 infants were diagnosed with transient hearing loss.
6.	Field Name:	Core RUSP Conditions - Referred For Treatment
	Fiscal Year:	2018
	Column Name:	Core RUSP Conditions
	Field Note:	The 2 infants with transient hearing loss were scheduled a follow up audiology visit with a specialist to confirm diagnosis. In addition, the Helping Babies Hearing Screening Program has worked with early intervention programs like the Part C-Helping Hands and Part B- DOE-SPED to ensure that they are connected with the families with appropriate resources.
7.	Field Name:	Rheumatic Heart Screening - Receiving At Least One Screen
	Fiscal Year:	2018
	Column Name:	Older Children & Women
	Field Note:	A total of 928 older children (age 1 to 17 years) and women (age 18 to 37 years) were screened for rheumatic heart disease from January to December 2018. There were three main RHD Screening Programs: MCH-RHD Program, Brigham Young University BYU RHD Relief Program and Oregon Health Sciences University (OHSU) RHD Program for 2018. A total of 816 older children and women were screened by the BYU RHD Program, 67 older children and women were screened by the OHSU program and 45 older children and women were screened by the MCH-RHD program.
8.	Field Name:	Rheumatic Heart Screening - Positive Screen
	Fiscal Year:	2018
	Column Name:	Older Children & Women
	Field Note:	RHD presumptive positive screens were defined as older children and women who did not pass their initial echocardiogram scan (i.e. sonographers detected heart irregularities). A total of 25 older children were identified by all three programs to be RHD positive screens. The BYU RHD program identified 13 presumptive RHD screens (age 6 to 12 years), the OHSU RHD program identified 9 presumptive RHD screens (age 6 to 17 years), and the MCH-RHD program identified 3 presumptive RHD screens (age 14 to 18 years).
9.	Field Name:	Rheumatic Heart Screening - Confirmed Cases

	Fiscal Year:	2018
	Column Name:	Older Children & Women
	Field Note:	RHD confirmed cases were defined as older children and women with a second echocardiogram scan result of "borderline RHD" and "definite RHD" according to the World Heart Federation (WHF) guidelines. A total of 20 older children were identified by all three programs to be confirmed RHD cases. The BYU RHD program identified 8 RHD confirmed cases (age 6 to 16 years), the OHSU RHD program identified 9 RHD confirmed cases (age 6 to 17 years), and the MCH-RHD program identified 3 RHD confirmed cases (age 14 to 18 years).
10.	Field Name:	Rheumatic Heart Screening - Referred For Treatment
	Fiscal Year:	2018
	Column Name:	Older Children & Women
	Field Note:	All 20 RHD confirmed cases (borderline and definite RHD according to WHF guidelines) were referred to treatment. Available treatment at the only local hospital include bicillin injections every 21 days.
11.	Field Name:	Group B Strep Screening - Receiving At Least One Screen
	Fiscal Year:	2018
	Column Name:	Older Children & Women
	Field Note:	A total of 266 pregnant women who gave birth from January 1 to December 31 2018 were screened for Group B Strep during their third trimester of pregnancy. GBS screening is a routine vagina and rectum swab of pregnant women to determine if there is high presence of the group B strep bacteria.
12.	Field Name:	Group B Strep Screening - Positive Screen
	Fiscal Year:	2018
	Column Name:	Older Children & Women
	Field Note:	A total of 210 pregnant women who gave birth from January to December 2018 were identified as presumptive positives of GBS. Presumptive positive screens include those with had a positive result of GBS in previous pregnancies and had a frequent history of urinary tract infections during the pregnancy.
13.	Field Name:	Group B Strep Screening - Confirmed Cases
	Fiscal Year:	2018
	Column Name:	Older Children & Women
	Field Note:	Of the 210 presumptive positive screens, a total of 105 pregnant women who gave birth in 2018 (Jan-Dec) were confirmed cases of the Group B Strep (GBS) infection. GBS infection is characterized as a cell culture of the vaginal or rectum sample with a high occurrence of Group B Strep.

14. **Field Name:** **Group B Strep Screening - Referred For Treatment**

Fiscal Year: **2018**

Column Name: **Older Children & Women**

Field Note:

All 105 of the confirmed cases were referred for treatment which consists of antibiotics prescribed at least 5 weeks before estimated delivery date. Antibiotics were also given through GBS positive pregnant women's IV during delivery.

Data Alerts: None

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

State: American Samoa

Annual Report Year 2018

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

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	925	100.0	0.0	0.0	0.0	0.0
2. Infants < 1 Year of Age	1,026	100.0	0.0	0.0	0.0	0.0
3. Children 1 through 21 Years of Age	8,188	100.0	0.0	0.0	0.0	0.0
3a. Children with Special Health Care Needs	104	100.0	0.0	0.0	0.0	0.0
4. Others	1,012	100.0	0.0	0.0	0.0	0.0
Total	11,151					

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	1,009	No	1,344	69	927	925
2. Infants < 1 Year of Age	1,004	No	1,076	96	1,033	1,026
3. Children 1 through 21 Years of Age	21,274	No	20,608	40	8,243	8,188
3a. Children with Special Health Care Needs	Not Available	No	135	78	105	104
4. Others	29,226	No	6,632	16	1,061	1,012

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2018
	Field Note:	A total of 925 pregnant women were served by Title V paid staff members who offered both direct (preventive clinical services) and enabling services (health education) from January 1 to December 31 2018. Of the 925 total pregnant women served by Title V staff members, 582 pregnant women were served during the first trimester of pregnancy, 236 pregnant women served during second trimester of pregnancy and 107 pregnant women served during third trimester of pregnancy.
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2018
	Field Note:	A total of 1026 infants less than 1 year of age infants were served by Title V paid staff members for both direct and enabling services which included well child visits, and immunization. (Source: AS Web IZ, 2019)
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2018
	Field Note:	A total of 8188 children 1 through 21 years of age were served by Title V paid staff members for both direct (preventive clinical services including immunizations) and enabling services (health education, care coordination and school based screening programs). (Source: CHC UDS Report, 2018)
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2018
	Field Note:	According to the MCH Children with Special Health Care Needs Client Navigator, a total of 104 individuals age 0 to 21 years are served by Title V staff in 2018 from January to December.
5.	Field Name:	Others
	Fiscal Year:	2018
	Field Note:	A total of 1012 non-pregnant women age 22 to 44 years were served by Title V staff members from Jan. 1 to Dec. 31 2018 for both direct (preventive clinical services: cervical cancer and breast cancer screening) and enabling services (health education).

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2018
	Field Note:	<p>There was a total of 1344 pregnant women served both by Title V paid staff members and non-Title V paid staff members from Jan. to Dec 2018 in American Samoa. Specifically, a total of 925 pregnant women were served by Title V paid staff members and 419 pregnant women were served by non-Title V paid staff members in 2018.</p> <p>Therefore the total percentage of pregnant women served by title V paid staff members are as follows: $925/1344 = 69\%$</p>
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2018
	Field Note:	<p>A total of 1076 infants age less than 1 year of age were served by both Title V staff members (direct and enabling services) and non-Title V staff members (public health systems). Source (CHC UDS Report, 2018) Therefore the total % served by title V staff members is $1026/1076 = 95.4\%$</p>
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2018
	Field Note:	<p>A total of 20608 children age 1 through 21 years of age in 2018 was identified. (Source: US Census International, 2018).</p> <p>Therefore the total % served by title V was calculated as follows: $8188/20608 = 39.7\%$</p>
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2018
	Field Note:	<p>A total of 135 children with special health care needs were served by the MCH Title V staff members care coordination program (104 CSHCN age 0 to 21 years) and the Part C Intervention Program, Helping Hands (31 CSHCN age 0 to 3 years) from January to December 2018.</p> <p>Total percentage of CSHCN served by MCH: $104 \text{ (MCH direct/enabling services)} / 135 \text{ (MCH direct/enabling services and public health systems)} * 100 = 77\%$</p>
5.	Field Name:	Others
	Fiscal Year:	2018

Field Note:

A total of 6632 non-pregnant women age 22 to 44 years were identified for American Samoa from Jan 1 to Dec 31 2018. (7808 women age 22-44 years, 2018 US Census International)- (1176 pregnant women age 22-44 years, 2018 UDS Report).

Therefore total % served by title V is as follows: $1012/6632 = 15.3\%$

Data Alerts:

1.	Pregnant Women, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
3.	Children 1 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
4.	Children With Special Health care Needs, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
5.	Others, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

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

State: American Samoa

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	931	4	0	0	0	24	903	0	0
Title V Served	931	4	0	0	0	24	903	0	0
Eligible for Title XIX	931	4	0	0	0	24	903	0	0
2. Total Infants in State	931	4	0	0	0	24	903	0	0
Title V Served	931	4	0	0	0	24	903	0	0
Eligible for Title XIX	931	4	0	0	0	24	903	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2018
	Column Name:	Total

Field Note:

The total deliveries in state for 2018 (January to December) was 930, which includes both live births, stillbirths, and deceased infants. There was a total of 913 live births, 15 stillbirths and 2 deceased infants from January to December 2018. A stillbirth was defined as a fetus who was delivered with a gestational age of 28 weeks or more. A deceased infant was defined as one who was delivered but was expired a day to 7 days after birth.

A total of 925 births occurred in the hospital and 5 births occurred outside of the hospital (i.e. home delivery or enroute to the hospital). All home births were live births and a total of 15 stillbirths (28 weeks gestation or more) were recorded in the hospital.

2.	Field Name:	1. Title V Served
	Fiscal Year:	2018
	Column Name:	Total

Field Note:

A total of

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

State: American Samoa

Toll-Free numbers are not available to all jurisdictions.

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number		
2. State MCH Toll-Free "Hotline" Name		
3. Name of Contact Person for State MCH "Hotline"		
4. Contact Person's Telephone Number		
5. Number of Calls Received on the State MCH "Hotline"		

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	Tina Maitaga ma Fanau	
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites	https://www.facebook.com/mc_hamericansamoa/?ref=bookmarks	https://www.facebook.com/mc_hamericansamoa/?ref=bookmarks
6. Number of Hits to the State Title V Program Social Media Websites		11,112

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: American Samoa

1. Title V Maternal and Child Health (MCH) Director	
Name	Margaret Seseapasara
Title	Program Director
Address 1	PO Box 5666
Address 2	
City/State/Zip	Pago Pago / AS / 96799
Telephone	(684) 633-1944
Extension	
Email	msesepasara@doh.as

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Anaise M Uso
Title	Program Coordinator
Address 1	PO Box 3378
Address 2	
City/State/Zip	Pago Pago / AS / 96799
Telephone	(684) 633-4008
Extension	
Email	anaise@doh.as

3. State Family or Youth Leader (Optional)

Name	Ipuniuese Eliapo-Unutoa
Title	CSHCN/RHD Coordinator
Address 1	PO Box 3378
Address 2	
City/State/Zip	Pago Pago / AS / 96799
Telephone	(684) 633-4008
Extension	
Email	ieliapo@doh.as

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: American Samoa

Application Year 2020

No.	Priority Need
1.	Promote preventive medical visits for women ages 21-44.
2.	Promote breastfeeding for infants 0-6 months.
3.	Promote evidence based developmental screenings for children 0-3 years of age.
4.	Promote Oral Health for children ages 0 -3 years.
5.	Promote immunization coverage for children ages three.
6.	Reduce Rheumatic Fever and Rheumatic Heart Disease.
7.	Promote preventive medical visits for adolescents ages 12-17.
8.	Improve system of care for CYSHCN..
9.	Promote care coordination services for children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV.
10.	Reduce pregnant women diagnosed with Zika viral infection.

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

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

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 1

Field Note:

Continued

Field Name:

Priority Need 2

Field Note:

Continuing this priority.

Field Name:

Priority Need 3

Field Note:

Continuing with priority.

Field Name:

Priority Need 4

Field Note:

Continuing with this priority.

Field Name:

Priority Need 5

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 6

Field Note:

Rheumatic heart disease is still a priority.

Field Name:

Priority Need 10

Field Note:

According to the Department of Health Laboratory, a total of 71 pregnant women were screened in 2018 (January to February 2018). Results show that there were 0 PCR positive for Zika and 1 Zika PRNT positive. Date of last pregnant women screened was December 10, 2018.

**Form 10
National Outcome Measures (NOMs)**

State: American Samoa

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

None

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

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

State Provided Data	
	2018
Annual Indicator	35.3
Numerator	324
Denominator	918
Data Source	MCH Postpartum Cards, EHR, LBJ Nursery
Data Source Year	2018

NOM 1 - Notes:

According to the MCH Postpartum Card data confirmed by the Electronic Health Record (E.H.R.) system, a total of 324 live births were reported to have their first prenatal visit during the first trimester (before 13 weeks gestation). A total of 918 live births were identified in the MCH Postpartum and LBJ Nursery data, which both have been confirmed on the EHR system.

Furthermore, a total of 353 live births were reported to have their first prenatal visit during the second trimester (13 to 26 weeks gestation), and a total of 162 live births were reported to have their first prenatal visit during the third trimester (27 weeks gestation to end of pregnancy). A total of 79 live births did not receive prenatal care during their pregnancy.

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	137.0
Numerator	3
Denominator	219
Data Source	LBJ Nursery Records and Electronic Health Records
Data Source Year	2018

NOM 2 - Notes:

Numerator: According to the MCH Postpartum and LBJ Nursery data, 3 hospitalized deliveries with an indication of severe morbidity, specifically sepsis were identified.

Denominator: According to the MCH Postpartum and LBJ Nursery data, 219 hospitalized deliveries, specifically mothers with C-section deliveries were identified.

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	918
Data Source	Vital Statistics Office, LBJ Nursery, E.H.R.
Data Source Year	2018

NOM 3 - Notes:

Of the 931 occurrent births (includes both live births, and still births), only one pregnant woman died in 2018. She did not receive any prenatal care during the pregnancy, she had a C-section delivery and an intrauterine fetal demise (IUFD) at 27 weeks gestation. However, the mother died 64 days after giving birth and therefore does not meet the definition of death occurring within 42 days of the end of pregnancy.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 3. Please review your data to ensure this is correct.
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NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	4.2 %	0.6 %	41	975
2016	5.2 %	0.7 %	53	1,012
2015	3.2 %	0.5 %	34	1,078
2014	4.5 %	0.6 %	49	1,077
2013	3.3 %	0.6 %	36	1,077
2012	5.2 %	0.7 %	61	1,163
2011	4.3 %	0.6 %	54	1,255
2010	3.7 %	0.5 %	46	1,234
2009	2.7 %	0.4 %	36	1,340

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	4.2
Numerator	39
Denominator	918
Data Source	MCH Postpartum and LBJ Nursery data, E.H.R.
Data Source Year	2018

NOM 4 - Notes:

A total of 39 live births weighing less than 2500 grams were identified from the MCH Postpartum and LBJ Nursery data, which have been confirmed by Electronic Health Records. A total of 918 live births were identified for 2018.

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	8.0
Numerator	73
Denominator	918
Data Source	MCH Postpartum and LBJ Nursery, EHR
Data Source Year	2018

NOM 5 - Notes:

Numerator: A total of 73 live births with a gestational age at birth of less than 37 weeks were identified from MCH Postpartum and LBJ Nursery data, which were confirmed by Electronic Health Records

Denominator: Total live births of 918 for 2018.

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	15.6
Numerator	143
Denominator	918
Data Source	MCH Postpartum and LBJ Nursery Records, EHR
Data Source Year	2018

NOM 6 - Notes:

Numerator: A total of 143 live births with a gestational age at birth of 37 and 38 weeks were identified from MCH Postpartum and LBJ Nursery data , and were confirmed by Electronic Health Records.

Denominator: Total live births of 918 for 2018.

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	204
Data Source	LBJ Nursery Data and Electronic Health Records
Data Source Year	2018

NOM 7 - Notes:

According to the MCH Postpartum and LBJ Nursery data confirmed by EHR, there were 0 non-medically indicated elective deliveries in 2018. OBGYN providers have also noted that it is part of the hospital protocol that any non-medically indicated elective delivery is not to be performed. In addition, a total of 204 deliveries at 37, 38 weeks' gestation without conditions possibly justifying elective delivery were identified.

Data Alerts:

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

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

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

State Provided Data	
	2018
Annual Indicator	18.3
Numerator	17
Denominator	931
Data Source	Vital Statistics Death Data, LBJ Nursery, EHR
Data Source Year	2018

NOM 8 - Notes:

Numerator: A total of 13 fetal deaths 28 weeks or more gestation plus a total of 4 early neonatal deaths occurring under 7 days. (13+4=17)

The primary source of death data was provided by the Office of Vital Statistics, specifically a list of individuals who have been issued death certificates. All 17 fetal deaths were confirmed on the Electronic Health Records.

Denominator: A total of 918 live births plus 13 fetal deaths at 28 weeks or more gestation. (918+13= 931)

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	5.4
Numerator	5
Denominator	918
Data Source	Vital Statistics Office, MCH Postpartum Cards, EHR
Data Source Year	2018

NOM 9.1 - Notes:

Numerator: A total of 5 infant deaths from birth through 364 days of age from the MCH Postpartum and LBJ Nursery data, which were confirmed by Electronic Health Records.

Denominator: A total of 918 live births were identified for 2018.

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	5.4
Numerator	5
Denominator	918
Data Source	Vital Statistics Office, MCH Postpartum Cards, EHR
Data Source Year	2018

NOM 9.2 - Notes:

Numerator: A total of 5 deaths to infants under 28 days were identified on the MCH Postpartum and LBJ Nursery data, which was confirmed by the Electronic Health Record. Such neonatal deaths are related to low birth weight and low gestational age of less than 37 weeks.

Denominator: A total of 918 live births were identified for 2018.

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	918
Data Source	Vital Statistics Office, MCH Postpartum Card, EHR
Data Source Year	2018

NOM 9.3 - Notes:

Numerator: A total of 0 deaths to infants 28 through 364 days of age were identified on the MCH Postpartum and LBJ Nursery confirmed by the Electronic Health Record.

Denominator: A total of 918 live births identified for 2018.

Data Alerts:

- | | |
|----|---|
| 1. | A value of zero has been entered for the numerator in NOM 9.3. Please review your data to ensure this is correct. |
|----|---|

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

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

State Provided Data	
	2018
Annual Indicator	435.7
Numerator	4
Denominator	918
Data Source	Vital Statistics Office, MCH Postpartum, EHR,
Data Source Year	2018

NOM 9.4 - Notes:

Numerator: A total of 4 deaths (<37 weeks gestation at birth) due to preterm-related causes were identified in the MCH Postpartum and LBJ Nursery data. Preterm deaths were live births who later died after birth. Preterm related causes include infants born with low birth weight (<2500g).

Denominator: A total of 918 live births in 2018.

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

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	918
Data Source	Office of Vital Statistics Death Data.
Data Source Year	2018

NOM 9.5 - Notes:

Numerator: According to death data released by the Office of Vital Statistics, there were no deaths that were sleep-related SUID deaths, including SIDS (R95), unknown cause (R99), and accidental suffocation and strangulation in bed (W75)

Denominator: A total of 918 live births in 2018.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 9.5. Please review your data to ensure this is correct.
----	---

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	918
Data Source	MCH Postpartum Data and Electronic Health Records
Data Source Year	2018

NOM 10 - Notes:

Numerator: According to the MCH Postpartum data in addition to the Electronic Health Records, there were no women who reported drinking alcohol in the last 3 months of pregnancy

Denominator: A total of 918 number of live births in 2018.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 10. Please review your data to ensure this is correct.
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NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	918
Data Source	aMCH Postpartum and LBJ nursery data and EHR.
Data Source Year	2018

NOM 11 - Notes:

Numerator: The MCH Postpartum and LBJ nursery data have both shown that there are no infants born with neonatal abstinence syndrome in 2018.

Denominator: A total of 925 hospital births in 2018.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 11. Please review your data to ensure this is correct.
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NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	6.1
Numerator	1,041
Denominator	17,104
Data Source	CHC Dental Services
Data Source Year	2018

NOM 14 - Notes:

Numerator: A total of _ children ages 1 through 17 who have decayed teeth or cavities in the past year.

Denominator: According to the US Census International, it is estimated that American Samoa has a total of 17104 children ages 1 through 17

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	NR 	NR 	NR 	NR 
2016	NR 	NR 	NR 	NR 
2015	NR 	NR 	NR 	NR 
2014	NR 	NR 	NR 	NR 
2013	NR 	NR 	NR 	NR 
2012	NR 	NR 	NR 	NR 
2011	NR 	NR 	NR 	NR 
2010	NR 	NR 	NR 	NR 
2009	108.4 	34.3 	10 	9,222 

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

State Provided Data	
	2018
Annual Indicator	34.0
Numerator	3
Denominator	8,821
Data Source	Vital Statistics Death Data, US Census Int. Data
Data Source Year	2018

NOM 15 - Notes:

Numerator: A total of 3 deaths among children ages 1 through 9 years were identified from the death data released by the Office of Vital Statistics. Causes of death were unknown for 2 of the children, and the other child is suspected to have brain death.

Denominator: A total of 8821 children ages 1 through 9 years for American Samoa in 2018 was estimated by the US Census International Database.

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

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

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	49.3
Numerator	5
Denominator	10,139
Data Source	Vital Statistics Death Data, US Census Int. Data
Data Source Year	2018

NOM 16.1 - Notes:

Numerator: A total of 5 deaths among adolescents ages 10 through 19 years were identified from the death data released by the Office of Vital Statistics. Causes of death for the adolescents include: suicide (2 adolescents), drowning (1 adolescent), cardiovascular related event (1 adolescent), and known case of neurofibromatosis (1 adolescent).

Denominator: A total of 10139 adolescents ages 10 through 19 years were identified by the US Census International Database.

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
2008_2010	NR	NR	NR	NR
2007_2009	NR	NR	NR	NR

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	4,882
Data Source	Vital Statistics Death Data, US Census Int. Data
Data Source Year	2018

NOM 16.2 - Notes:

Numerator: According to the Office of Vital Statistics Death data, no deaths were reported for adolescents ages 15 through 19 years caused by motor vehicle crashes, which includes all occupant, pedestrian, motorcycle, bicycle, etc. deaths caused by motor vehicles

Denominator: According to the US Census International data, it is estimated that the total number of adolescents ages 15 through 19 years in American Samoa is 4882 for 2018.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 16.2. Please review your data to ensure this is correct.
----	--

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
2008_2010	NR	NR	NR	NR
2007_2009	NR	NR	NR	NR

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	41.0
Numerator	2
Denominator	4,882
Data Source	Vital Statistics Death Data, US Census Int. Data
Data Source Year	2018

NOM 16.3 - Notes:

Numerator: According to the Office of Vital Statistics Death data, a total of 2 deaths were attributed to suicide among youths ages 15 through 19 years in 2018

Denominator: According to the US Census International data, it is estimated that the total number of adolescents ages 15

through 19 years in American Samoa is 4882 for 2018.

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

State Provided Data	
	2018
Annual Indicator	0.7
Numerator	119
Denominator	18,063
Data Source	MCH-CSCHN, and Helping Hands Part C
Data Source Year	2018

NOM 17.1 - Notes:

Numerator: A total of 119 children, ages 0 through 17 years met the criteria for having a special health care need based on the CSHCN screener. A total of 88 children ages 0 through 17 years met the CSHCN criteria in the MCH program, and a total of 31 children ages 0 through 3 years met the CSHCN criteria in the Part C, Helping Hands Early Intervention Program.

Denominator: According to the US Census International data, it is estimated that the total number of children ages 0 through 17 years in American Samoa is 18063 for 2018.

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	73.9
Numerator	88
Denominator	119
Data Source	MCH CSHCN and Helping Hands, Part C
Data Source Year	2018

NOM 17.2 - Notes:

Numerator: A total of 88 CSHCN ages 0 through 17 years receive all components of a well-functioning system (family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition) through the MCH CSHCN program.

Denominator: A total of 119 CSHCN ages 0 through 17 were identified through CSHCN programs: MCH-CSHCN and Helping Hands, Part C Early Intervention.

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

State Provided Data	
	2018
Annual Indicator	0.1
Numerator	8
Denominator	15,159
Data Source	MCH-CSCHN client navigator list and US Census Int.
Data Source Year	2018

NOM 17.3 - Notes:

Numerator: A total of 8 children, ages 3 through 17 were reported by their parents to have been diagnosed by a health care provider with ASD and to currently have the condition. Parents reported the ASD relevant information to the MCH-CSCHN client navigator.

Denominator: A total of 15159 children, ages 3 through 17 in American Samoa for 2018 was estimated by the US Census International Database.

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	1
Denominator	15,159
Data Source	MCH CSHCN Client Navigator and US Census Int.
Data Source Year	2018

NOM 17.4 - Notes:

Numerator: One child age 3 to 17 years was reported by their parents to have been diagnosed by a health care provider with ADD/ADHD and to currently have the condition

Denominator: A total of 15159 children, ages 3 through 17 in American Samoa for 2018 was estimated by the US Census International Database.

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

State Provided Data	
	2018
Annual Indicator	100.0
Numerator	1
Denominator	1
Data Source	MCH CSHCN Client Navigator
Data Source Year	2018

NOM 18 - Notes:

Numerator: One child age 3 to 17 years was reported by her parents to have been diagnosed by a health care provider with anxiety problems, and currently has the condition and also received treatment or counseling in the last year.

Denominator: This is the only children reported by parents to have been diagnosed by a health care provider with a mental/behavioral condition.

*Data for both numerator and denominator is the from the the MCH-CSHCB Client Navigator, 2018.

Data Alerts: None

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

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

NOM 19 - Notes:

NOM19 data is not available. However, the 2019 MCH Jurisdictional Survey for American Samoa has collected this data.

Data Alerts:

1.	Data has not been entered for NOM 19. This outcome measure is linked to the selected NPM 6,11,10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.
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NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	16.3 %	0.7 %	514	3,160
2012	14.7 %	0.6 %	478	3,251
2010	14.6 %	0.6 %	470	3,221
2008	19.3 %	0.7 %	603	3,119

Legends:

- Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	41.5 %	0.9 %	1,512	3,644
2011	39.2 %	0.9 %	1,443	3,679
2007	38.6 %	0.8 %	1,403	3,633

Legends:

- Indicator has an unweighted denominator <100 and is not reportable
- Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

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

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

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

State Provided Data	
	2018
Annual Indicator	27.8
Numerator	806
Denominator	2,902
Data Source	Immunization Office Web IZ and US Census Int.
Data Source Year	2018

NOM 22.1 - Notes:

Numerator: A total of 806 children, ages 19 through 35 months completed the combined 7-vaccine series (4:3:1:3*:3:1:4) in 2018.

Denominator: The US Census International Database has estimated a total of 2902 children, ages 19 through 35 months for American Samoa in 2018.

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

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

State Provided Data	
	2018
Annual Indicator	0.3
Numerator	54
Denominator	18,063
Data Source	Immunization Office, Web IZ Registry system
Data Source Year	2018

NOM 22.2 - Notes:

Numerator: According to the Office of Immunization web based registry system, Web Iz, a total of 54 children 6 months through 17 years were vaccinated annually against seasonal influenza in 2018.

Denominator: According to the US Census International Database, there is a total of 17,104 children 6 months through 17 years in 2018.

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

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

State Provided Data	
	2018
Annual Indicator	77.2
Numerator	4,099
Denominator	5,309
Data Source	Immunization Records, Web IZ and US Census Int.
Data Source Year	2018

NOM 22.3 - Notes:

Numerator: A total of 4099 unduplicated number of adolescents, ages 13 through 17, have received at least one dose of the HPV vaccine, according to the Office of Immunization Records, Web Registry System, Web IZ by 2018 (01/01/18 to 12/31/18).

Denominator: The US Census International Database has estimated a total of 5309 adolescents, ages 13 through 17 years for American Samoa in 2018.

Numerator: According to the Office of Immunization web based registry system, Web IZ, a total of 4266 adolescents, ages 13 through 17 have received at least one dose of the HPV vaccine in 2018.

Denominator: According to the US Census International 2018 data, there is a total of 5309 adolescents, ages 13 through 17 years.

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2018
Annual Indicator	72.7
Numerator	3,862
Denominator	5,309
Data Source	Immunization Office, Web IZ and US Census Int.
Data Source Year	2018

NOM 22.4 - Notes:

Numerator: According to the Office of Immunization web based registry system, Web IZ, a total of adolescents, ages 13 through 17 have received at least one dose of the Tdap vaccine in 2018.

Denominator: According to the US Census International 2018 data, there is a total of 5309 adolescents, ages 13 through 17 years.

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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

State Provided Data	
	2018
Annual Indicator	71.3
Numerator	3,787
Denominator	5,309
Data Source	Immunization Office, Web IZ and US Census Int.
Data Source Year	2018

NOM 22.5 - Notes:

Numerator: A total of 3787 unduplicated number of adolescents, ages 13 through 17, have received at least one dose of the meningococcal conjugate vaccine, according to the Office of Immunization Records, Web Registry System, Web Iz by 2018 (01/01/18 to 12/31/18).

Denominator: The US Census International Database has estimated a total of 5309 adolescents, ages 13 through 17 years for American Samoa in 2018.

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	38.4	4.0	92	2,395
2016	40.8	4.1	99	2,425
2015	42.3	4.1	105	2,485
2014	46.0	4.2	118	2,565
2013	45.6	4.1	125	2,741
2012	44.1	3.9	129	2,922
2011	43.7	3.8	133	3,045
2010	38.6	3.5	119	3,080
2009	42.8	3.8	130	3,037

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	22.5
Numerator	54
Denominator	2,401
Data Source	MCH Postpartum, LBJ Nursery EHR and US Census Int.
Data Source Year	2018

NOM 23 - Notes:

Numerator: A total of 54 births to adolescents, ages 15 through 19 years occurred in 2018 from January to December according to the MCH Postpartum and LBJ Nursery data which have been confirmed by the Electronic Health Records System. All 54 teen births were live births, however, one infant expired within hours after birth.

Denominator: A total of 2401 adolescent females, ages 15 through 19 years was estimated by the US Census International Database for American Samoa in 2018.

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

NOM 24 - Notes:

Unfortunately, there is a significant underreporting of postpartum depressive symptoms following a recent live birth (defined as reporting always/often feeling down, depressed, hopeless or always/often having little interest or little pleasure in doing things). A protocol is not in place to address postpartum depressive symptoms during women's postpartum visits.

Data Alerts:

1.	Data has not been entered for NOM 24. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.
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NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

NOM 25 - Notes:

There is a significant underestimation of the number of children, ages 0 through 17 years, who were reported by a parent to not able to obtain needed health care in the last year. A protocol is not in place to acquire such information.

Data Alerts:

1.	Data has not been entered for NOM 25. This outcome measure is linked to the selected NPM 11,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.
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**Form 10
National Performance Measures (NPMs)**

State: American Samoa

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

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

State Provided Data			
	2016	2017	2018
Annual Objective	0.1	0.2	9.7
Annual Indicator	9.4	9.5	27.5
Numerator	918	921	2,633
Denominator	9,720	9,720	9,561
Data Source	Postpartum Data	Postpartum Data	CHC UDS Report, US Census International Database
Data Source Year	2016	2017	2018
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9.9	10.0	10.5	11.0	11.5	12.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 2633 unduplicated number of women, ages 18 through 44 had a preventive medical visit in the past year at the Community Health Center. Preventive medical visits range from screening (i.e. cervical cancer screening- pap smears etc.) counseling (weight management and diabetes, oral health and dental caries etc.), and immunizations (seasonal flu vaccine etc.)

Denominator: A total of 9561 women, ages 18 through 44 were estimated by the US Census International Database for American Samoa in 2018.

NPM 4A - Percent of infants who are ever breastfed

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

State Provided Data			
	2016	2017	2018
Annual Objective	82	83	86
Annual Indicator	76	75	68.2
Numerator	765	750	626
Denominator	1,007	1,000	918
Data Source	American Samoa WIC	Postpartum Data	AS WIC, MCH Postpartum and LBJ Nursery,
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	86.7	87.0	87.5	88.0	88.5	88.5

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 626 infants who were ever breastfed was reported by the Women Infant Children (WIC) Program of American Samoa for 2018 (January to December).

Denominator: A total of 918 live births were reported by the MCH Postpartum and LBJ Nursery data which was confirmed by Electronic Health Records for 2018 (January to December).

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	20	21	43
Annual Indicator	54.3	52.1	44.3
Numerator	486	521	407
Denominator	895	1,000	918
Data Source	AS WIC	ASWIC	AS WIC, MCH Postpartum and LBJ Nursery,
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	43.5	44.0	44.5	46.0	46.5	47.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 407 infants who were breastfed exclusively through 6 months was reported by the Women Infant Children (WIC) Program of American Samoa for 2018 (January to December).

Denominator: A total of 918 live births were reported by the MCH Postpartum and LBJ Nursery data which was confirmed by Electronic Health Records for 2018 (January to December).

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

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

State Provided Data			
	2016	2017	2018
Annual Objective			5
Annual Indicator	2.5	2.5	1.3
Numerator	180	180	49
Denominator	7,339	7,339	3,861
Data Source	Part c and MEICHV	Part c and MEICHV	MCH CSHCN and Part C Helping Hands Early Intv.
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	10.0	15.0	20.0	21.0	22.0	10.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of unduplicated 49 children, ages 9 through 35 months (2 years), whose parents completed a Standardized Developmental Screening tool in the past year were reported by the MCH CSHCN Program (18 children ages 9 through 35 months) and Helping Hands (31 children ages 9 through 35 months).

Denominator: A total of 3861 children, ages 0 through 3 years were estimated by the US Census International for American Samoa in 2018.

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			60
Annual Indicator	59.2	39.6	39.8
Numerator	4,561	5,049	2,555
Denominator	7,710	12,758	6,414
Data Source	AS CHC and Immunization Program	AS CHC and Immunization Program	Immunization Office Registry Web IZ US Census Int.
Data Source Year	2016	2016	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	61.0	62.0	63.0	64.0	65.0	65.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 2555 unduplicated number of adolescents, ages 12 through 17, with a preventive medical visit in 2018 was reported by the Office of Immunization Registry System, Web IZ. Adolescent immunizations occurred at Well Baby Clinics, three of four clinics are housed at 3 health centers and one independent well baby clinic. In addition, an unduplicated number of adolescents, ages 12 through 17 who were vaccinated at immunization outreach programs are included.

Denominator: A total of 6414 adolescents, ages 12 through 17 was estimated by the US Census International Database for 2018 from January to December.

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			72
Annual Indicator	71.8	74.3	43.3
Numerator	18,366	19,099	7,815
Denominator	25,579	25,722	18,063
Data Source	ASCHC and Immunization Program	ASCHC and Immunization Program	MCH CSHCN, Part C, CHC UDS Report
Data Source Year	2016	2016	2018
Provisional or Final ?	Final	Provisional	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	72.5	73.0	73.5	74.0	74.5	50.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 7815 children (135 children with special health care needs and 7680 children without special health care needs) ages 0 through 17, who met the criteria for having a medical home (personal doctor or nurse, usual source for care, and family-centered care; referrals or care coordination if needed) were reported by the following sources: MCH CSHCN (104 children ages 0-17y), Helping Hands Part C Early Intervention (31 children ages 0-3y) and the Community Health Center's Uniformed Data System (UDS) Report for 2018.

Denominator: The US Census International Database has estimated a total of 18063 children, ages 0 through 17 for American Samoa in 2018.

**Form 10
State Performance Measures (SPMs)**

State: American Samoa

SPM 1 - Percent of Pregnant Women who tested Positive for Zika.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		20	19	
Annual Indicator	23.6	23.6	0	
Numerator	49	49	0	
Denominator	20,789	20,789	931	
Data Source	RHD registry 2016	RHD registry 2016	AS DOH Surveillance Office MCH Postpartum LBJ Nur.	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	18.0	17.0	16.0	15.0	14.0	0.0

Field Level Notes for Form 10 SPMs:

1. **Field Name:** 2016

Column Name: State Provided Data

Field Note:
This data was collected from the LBJ Pediatrics' list of new cases during the OHSU Cardiology Team's visit in November, 2016.

2. **Field Name:** 2018

Column Name: State Provided Data

Field Note:
Numerator: According to the American Samoa Department of Health Surveillance, there were no women reported to be diagnosed with Zika during Pregnancy in 2018 from January to December.

Denominator: A total of 931 occurrent births (both live and still births) were reported by the MCH Postpartum and LBJ Nursery data, confirmed by Electronic Health Records for 2018 from January to December.

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			1	
Annual Indicator	0.9	0.4	1.1	
Numerator	29	14	44	
Denominator	3,200	3,200	3,861	
Data Source	CHC Dental Clinics	CHC Dental Clinics	Tafuna CHC Dental Clinic	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.0	3.0	4.0	5.0	6.0	2.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 44 unduplicated children ages 1 through 3 were reported by the Dental Clinic of the Tafuna Community Health Centers with a preventive dental service in 2018 (Jan-Dec.)

Denominator: A total of 3861 children ages 1 through 3 years have been estimated by the US Census International Database for American Samoa in 2018.

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		4	51	
Annual Indicator	51.3	40.1	60.2	
Numerator	1,144	1,130	576	
Denominator	2,230	2,820	957	
Data Source	AS IP	ASIP	Immunization Office Registry Web IZ US Census Int.	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	51.2	51.5	52.0	53.0	54.0	65.0

Field Level Notes for Form 10 SPMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
 This data was pulled by CDC from the WEBIZ database back in July 2016, ASIP reported that 34% of children 19-35 months were up to date with their immunization (431334) in 2015. But with the introduction of the varicella vaccine, the up to date status was significantly affected (4313314) and hence the major drop in percentage.
- Field Name:** 2018

Column Name: State Provided Data

Field Note:
 Numerator: A total of 576 children age 3 who received 4:3:1:3(4):3:1:4 series of routine vaccinations was reported by the Office of Immunization Registry System, Web IZ in 2018 from January to December.

Denominator: A total of 957 children age 3 years have been estimated by the US Census International Database for American Samoa in 2018.

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			29	
Annual Indicator	23.6	28.9	15.1	
Numerator	49	60	20	
Denominator	20,789	20,789	13,248	
Data Source	RHD registry 2016	RHD registry	MCH RHD Registry (BYU, OSHU, MCH)	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	31.0	32.0	31.0	30.0	14.1

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 20 new cases of Rheumatic Heart Disease was diagnosed by RHD Screening Programs in 2018 from January to December (BYU: 8 new RHD cases, OSHU: 9 new RHD cases, MCH: 3 new RHD cases)

Denominator: A total of 13248 children and adolescents ages 5-17 years have been estimated by the US Census International for 2018 from January to December.

SPM 5 - Percent of families of children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV who reports they are satisfied with their care coordination services.

Measure Status:				Active		
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	25.0	30.0	35.0	40.0	69.0

Field Level Notes for Form 10 SPMs:

None

**Form 10
State Outcome Measures (SOMs)**

State: American Samoa

SOM 1 - RHD Mortality Rate for ages 5 - 17 years per 10,000.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			29	
Annual Indicator	23.6	28.9	0	
Numerator	49	60	0	
Denominator	20,789	20,789	13,248	
Data Source	RHD registry 2016	RHD Registry	Vital Statistics Death data, US Census Int.	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	31.0	32.0	31.0	30.0	0.0

Field Level Notes for Form 10 SOMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: According to the death data released by the Office of Vital Statistics, there were no reported deaths among children ages 5 through 17 years.

Denominator: The US Census International Database have estimated a total of 13248 children ages 5 through 17 years in American Samoa for 2018 from January to December.

**Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: American Samoa

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			50	
Annual Indicator	30	40	62.5	
Numerator	3	4	5	
Denominator	10	10	8	
Data Source	DOH Media	DOH Media	DOH MCH Media	
Data Source Year	2016	2016	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	60.0	70.0	80.0	90.0	100.0	70.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 5 media outlets were utilized to promote medical visits among women age 18 to 44 years in 2018, 4 local radio stations and 1 local TV station. Specifically, medical visits promoted were prenatal care offered at the Community Health Centers at no cost.

Denominator: There is a total 8 media outlets in American Samoa in 2018: 1 local newspaper, 4 local radio stations, 1 local TV station, 1 movie theater, and social media (Facebook).

ESM 1.2 - Percent of women registered during Women's Health Week for a preventive screenings.

Measure Status:		Active			
Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	35.0	36.0	37.0	38.0	40.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Percent of Pregnant Women who has heard of the “Fight the Bite” Zika Campaign

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	1.0	2.0	3.0	4.0	5.0	

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Number of MCH staff attended the Certified Lactation Counselor training.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			19	
Annual Indicator	0	18.2	0	
Numerator	0	2	0	
Denominator	13	11	13	
Data Source	ASMCH	ASMCH	AS MCH	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	21.0	22.0	23.0	24.0	24.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: In 2018, there were no MCH Staff who attended the Certified Lactation Counselor training.

Denominator: There was total of 13 MCH Staff in 2018.

ESM 4.2 - Percent of women participating at the Breastfeeding Week activities who confirm they are breastfeeding.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			49	14
Annual Indicator	14.4	13.2	23.8	
Numerator	110	113	134	
Denominator	765	856	562	
Data Source	WIC, CHC	WIC, CHC	WIC and MCH Health Educator	
Data Source Year	2015	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	14.1	14.5	15.0	16.0	17.0	24.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 134 women participated in the 2018 Breastfeeding Week Celebration according to the WIC program list and MCH Health educator list.

Denominator: A total of 562 postpartum women was confirmed by the MCH Postpartum and LBJ Nursery data confirmed by Electronic Health Records. The 562 postpartum women gave birth from January 1 to July 31 2018.

ESM 4.3 - Percent of postpartum mothers reported that they received breastfeeding resources and reminders after delivery and before discharge.

Measure Status:		Active			
Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	60.0	61.0	62.0	63.0	64.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - Number of Providers utilizing a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		51	40	
Annual Indicator	20	30	27.3	
Numerator	2	3	3	
Denominator	10	10	11	
Data Source	CHC Data	CHC Data	CHC UDS	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	60.0	70.0	80.0	90.0	40.0

Field Level Notes for Form 10 ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
 Medical Staff were introduced to examples of evidence-based Developmental Screening Tools and their significance in identifying children who need early intervention services in a timely manner. This CME training was done by Dr. Louise Iwaichi, Director of LEND Program in Hawaii and Chief of Pediatrics in Queens Medical Center.
- Field Name:** 2018

Column Name: State Provided Data

Field Note:
 Numerator: A total of 3 providers utilize a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months in 2018.

Denominator: There is a total of 11 providers in the Community Health Center in 2018.

ESM 6.2 - Percent of clinical staff trained in the standing operating procedures for referrals to Early intervention and other programs.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	50.0	55.0	60.0	65.0	70.0	

Field Level Notes for Form 10 ESMs:

None

ESM 6.3 - Percent of participants in Children’s Oral Health awareness month activities.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	10.0	15.0	20.0	25.0	30.0	

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Percent of schools covered by Immunization School Outreach Program.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			5	79
Annual Indicator	54.8	78.6	95.6	
Numerator	23	33	43	
Denominator	42	42	45	
Data Source	ASIP	ASIP	Immunization Office and MCH Epidemiologist	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	81.0	82.0	83.0	84.0	90.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: There was a total of 43 elementary and high schools that were covered by Immunization School Outreach Program in 2018 according to Office of Immunization Records and the MCH Epidemiologist who collected the data for the territory wide vaccine campaign in December 2018.

Denominator: According to the AS Department of Education list, there are 23 public elementary schools and 6 public high schools, in addition to 10 private elementary schools and 6 private high schools. Therefore the total number of elementary and high schools in AS is 45 schools.

ESM 10.2 - Number of high schools covered by Immunization School Outreach Program.

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	95.0	96.0	97.0	99.0	100.0	

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Percent of CSHCN families who received care coordination services from CSHCN staff in the past year.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			15	59
Annual Indicator	80	58.2	48.6	
Numerator	88	64	51	
Denominator	110	110	105	
Data Source	2016	2017	2018	
Data Source Year	CSHCN	CSHCN	CSHCN	
Provisional or Final ?	Provisional	Provisional	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	60.0	61.0	62.0	63.0	64.0	60.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Numerator: A total of 51 CSHCN (Age 1-21 years) received care coordination from CSHCN staff in 2018.

Denominator: There is a total of 105 CSHCN clients for the MCH CSHCN Program as of December 2018.

Form 10
State Performance Measure (SPM) Detail Sheets

State: American Samoa

SPM 1 - Percent of Pregnant Women who tested Positive for Zika.

Population Domain(s) – Women/Maternal Health

Measure Status:	Active									
Goal:	To reduce the number of Pregnant Women infected with Zika.									
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of Women diagnosed with Zika during Pregnancy.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Total number of Pregnant in the past year.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Rate</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>10,000</td> </tr> </table>		Numerator:	Number of Women diagnosed with Zika during Pregnancy.	Denominator:	Total number of Pregnant in the past year.	Unit Type:	Rate	Unit Number:	10,000
Numerator:	Number of Women diagnosed with Zika during Pregnancy.									
Denominator:	Total number of Pregnant in the past year.									
Unit Type:	Rate									
Unit Number:	10,000									
Healthy People 2020 Objective:	Maternal, Infant and Child Health Objective 6: Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery).									
Data Sources and Data Issues:	Public Health Surveillance Zika Registry.									
Significance:	<p>Zika Viral Infection during pregnancy can lead to microcephaly and other related neurological problems in infants. Establishing a state-level pregnancy registry reporting system to actively monitor pregnant women with suspected or confirmed Zika infection is the first step to monitoring and surveillance. Other strategies recommended by CDC to promote and reduce the number of pregnant women infected by Zika include: (1) Training healthcare providers who are counseling patients on how to reduce their risk of sexual transmission of the Zika virus and reduce unintended pregnancies through provision of effective contraception. (2) Advise patients, especially pregnant women and women trying to become pregnant, on how to reduce mosquito exposure. (3) Ensure obstetric providers increase screening for symptoms of Zika and adhere to the CDC guidelines for monitoring pregnant women in regions with local transmission. American Samoa is currently considered one of the US Territories with local transmission.</p>									

SPM 2 - Percent of children, ages 1 through 3 years, who had a preventive dental service in the past year.
Population Domain(s) – Child Health

Measure Status:	Active								
Goal:	To increase the percent of children ages 1 through 3 years who had a preventive dental service in the past year.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of children, ages 1 through 3, who had a preventive dental service in the past year.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of children ages 1 through 3 years.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of children, ages 1 through 3, who had a preventive dental service in the past year.	Denominator:	Total number of children ages 1 through 3 years.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children, ages 1 through 3, who had a preventive dental service in the past year.								
Denominator:	Total number of children ages 1 through 3 years.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	Related to Oral Health (OH) Objective 8. Increase the proportion of low-income children and adolescents who receive any preventive dental service during the past year. (Baseline: 30.2%, Target: 33.2%)								
Data Sources and Data Issues:	This is an integrated measure with two data sources: A) Community Health Center UDS report. B) National Survey of Children's Health (NSCH) once its available.								
Significance:	<p>American Samoa MCH Title V and its key partners recognizes that oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.</p> <p>Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits.</p> <p>State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</p>								

SPM 3 - Percent of children ages 3 who have completed their age-appropriate routine vaccinations.
Population Domain(s) – Child Health

Measure Status:	Active								
Goal:	Increase number of children ages 3 years of age who received the 4:3:1:3(4):3:1:4 series of routine vaccinations.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Total number of children ages 3 who received 4:3:1:3(4):3:1:4 series of routine vaccinations.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of children ages 3 years.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Total number of children ages 3 who received 4:3:1:3(4):3:1:4 series of routine vaccinations.	Denominator:	Total number of children ages 3 years.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Total number of children ages 3 who received 4:3:1:3(4):3:1:4 series of routine vaccinations.								
Denominator:	Total number of children ages 3 years.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	<p>11D-8. Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV)</p> <p>Baseline: 68.4 percent of children aged 19 to 35 months in 2012 received the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV.</p> <p>Target: 80%</p>								
Data Sources and Data Issues:	AS Immunization Program								
Significance:	<p>There is still a need to boost the number of kids completing their shots on time prior to school enrollment at Head Start in American Samoa.</p> <p>People in the United States continue to get diseases that are vaccine preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death in the United States and account for substantial spending on the related consequences of infection.</p> <p>Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule (this includes DTaP, Td, Hib, Polio, MMR, Hep B, and varicella vaccines), society:</p> <ul style="list-style-type: none"> Saves 33,000 lives. Prevents 14 million cases of disease. Reduces direct health care costs by \$9.9 billion. Saves \$33.4 billion in indirect costs. <p>Despite progress, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases.* Communities with pockets of unvaccinated and undervaccinated populations are at increased risk for outbreaks of vaccine-preventable diseases. In 2008, imported measles resulted in 140 reported cases—nearly a 3-fold increase over the previous year. The emergence of new or replacement strains of vaccine-preventable disease can result in a significant increase in serious illnesses and death.</p>								

SPM 4 - Rate per 10,000 children, ages 5 - 17, diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease. Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active								
Goal:	To reduce the rate of children and adolescents diagnosed with (A) Rheumatic Fever or (B) Rheumatic Heart Disease.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>(A) Number of new cases of Rheumatic Fever (B) Number of new cases of Rheumatic Heart Disease.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of children and adolescents ages 5-17 years.</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	(A) Number of new cases of Rheumatic Fever (B) Number of new cases of Rheumatic Heart Disease.	Denominator:	Total number of children and adolescents ages 5-17 years.	Unit Type:	Rate	Unit Number:	10,000
Numerator:	(A) Number of new cases of Rheumatic Fever (B) Number of new cases of Rheumatic Heart Disease.								
Denominator:	Total number of children and adolescents ages 5-17 years.								
Unit Type:	Rate								
Unit Number:	10,000								
Healthy People 2020 Objective:	<p>RHD and RF are unique to American Samoa and other Pacific Islands. By addressing this measure we hope to reduce Child and Adolescent Mortality rates in the future due to RHD.</p> <p>The related HP2020 would be for children mortality rates. Between 2007 and 2013, deaths of children, adolescents, and young adults per 100,000 population declined: aged 5–9 years (MICH-3.2) from 13.8 to 11.8; for adolescents aged 10–14 (MICH-4.1) from 16.5 to 14.1; for adolescents aged 15–19 (MICH-4.2) from 60.3 to 44.8; and for young adults aged 20–24 (MICH-4.3) from 98.1 to 83.4, exceeding their respective 2020 targets. This may not be the case in American Samoa.</p>								
Data Sources and Data Issues:	RHD Registry								
Significance:	Child and Adolescent Deaths from RHD are considered avoidable but in American Samoa its attributed to lack of preventive health care or timely and effective medical care. In the last 4-6 years, About five deaths were due to Rheumatic Heart Disease. Although, RHD is no longer reported in the US as significant causes of death among children, Rheumatic Fever and RHD is common in American Samoa still. This measure is included so that risk factors are addressed , or treating conditions (Strep throat) once they have occurred in order to prevent RF and or RF from developing into RHD.								

SPM 5 - Percent of families of children ages 0-3 years born with congenital ZIKV or born to pregnant women with ZIKV who reports they are satisfied with their care coordination services.

Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active								
Goal:	To improve care coordination for families and children with Congenital Zika or born to pregnant women diagnosed with Zika.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of families of infants and children who are residing in American Samoa born with congenital Zika or to pregnant women with Zika, reports they are satisfied with their care coordination services.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of families of infants and children residing in American Samoa born with congenital Zika or to pregnant women with Zika.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of families of infants and children who are residing in American Samoa born with congenital Zika or to pregnant women with Zika, reports they are satisfied with their care coordination services.	Denominator:	Total number of families of infants and children residing in American Samoa born with congenital Zika or to pregnant women with Zika.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of families of infants and children who are residing in American Samoa born with congenital Zika or to pregnant women with Zika, reports they are satisfied with their care coordination services.								
Denominator:	Total number of families of infants and children residing in American Samoa born with congenital Zika or to pregnant women with Zika.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	<p>Related to Maternal, Infant, and Child Health (MICH) Objectives 30.1: Increase the proportion of children who have access to a medical home, (Baseline: 57.5%, Target: 63.3%) and 30.2: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%)</p> <p>Related to Objective Maternal, Infant, and Child Health (MICH) Objective 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems. (Baseline: 20.4% for children aged 0-11, Target: 22.4%; Baseline: 13.8% for children aged 12 through 17, Target 15.2%)</p>								
Data Sources and Data Issues:	National Survey of Children's Health (NSCH) once available or MCH Title V survey.								
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home.								

Form 10
State Outcome Measure (SOM) Detail Sheets

State: American Samoa

SOM 1 - RHD Mortality Rate for ages 5 - 17 years per 10,000.

Population Domain(s) – Child Health

Measure Status:	Active								
Goal:	Decrease child and adolescent mortality rate ages 5 - 17 years due to RHD.								
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Number of deaths among children ages 5 through 17 years.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of children ages 5 through 17 years.</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	Number of deaths among children ages 5 through 17 years.	Denominator:	Total number of children ages 5 through 17 years.	Unit Type:	Rate	Unit Number:	10,000
Numerator:	Number of deaths among children ages 5 through 17 years.								
Denominator:	Total number of children ages 5 through 17 years.								
Unit Type:	Rate								
Unit Number:	10,000								
Healthy People 2020 Objective:	<p>RHD and RF is unique to American Samoa and other Pacific Islands. By addressing this measure we hope to reduce Child and Adolescent Mortality rates in the future due to RHD. The related HP2020 would be for children mortality rates. Between 2007 and 2013, deaths of children, adolescents, and young adults per 100,000 population declined: aged 5–9 years (MICH-3.2) from 13.8 to 11.8; for adolescents aged 10–14 (MICH-4.1) from 16.5 to 14.1; for adolescents aged 15–19 (MICH-4.2) from 60.3 to 44.8; and for young adults aged 20–24 (MICH-4.3) from 98.1 to 83.4, exceeding their respective 2020 targets. This may not be the case in American Samoa.</p>								
Data Sources and Data Issues:	LBJ Data & RHD Registry								
Significance:	<p>American Samoa is depicted as one of the highest rates of prevalence among children with Rheumatic Fever and/or Rheumatic Heart Disease. Rheumatic Heart Disease and Rheumatic Fever is highly prevalent in American Samoa due to many factors, some of which include environmental conditions and primary care prevention services. This cardiovascular disease greatly affects the overall health and outlook of children once diagnosed, not to mention the increased burden on the healthcare system of the Territory.</p> <p>Child and Adolescent Deaths from RHD are considered avoidable but in American Samoa its attributed to lack of preventive health care or timely and effective medical care. In the last 4-6 years, About five deaths were due to Rheumatic Heart Disease. Although, RHD is no longer reported in the US as significant causes of death among children, Rheumatic Fever and RHD is common in American Samoa still. This measure is included so that risk factors are addressed , or treating conditions (Strep throat) once they have occurred in order to prevent RF and or RF from developing into RHD.</p>								

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: American Samoa

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

NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active									
Goal:	Increase number of women ages 21 - 44 utilizing available preventive medical visits.									
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Number of media outlets utilized to promote medical visits.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of media outlets.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of media outlets utilized to promote medical visits.	Denominator:	Total number of media outlets.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of media outlets utilized to promote medical visits.									
Denominator:	Total number of media outlets.									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	ASMCH Title V									
Significance:	<p>Preconception health and other maternal diseases and risks/complications in future pregnancies and births can be addressed at medical preventive visits. This can help ensure that women receive adequate preventive health care and minimize complex problems that may derive from chronic illness or other risks factors that may lead to unfavorable conditions during pregnancies such as Gestational Diabetes. Women who are healthy prior to pregnancy usually have better pregnancy and birth outcomes than those who are not. There are ten media outlets in total:</p> <ul style="list-style-type: none"> - 5 radio local stations - 3 TV stations for advertisements - Movie Theater - Local newspaper 									

ESM 1.2 - Percent of women registered during Women's Health Week for a preventive screenings.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active	
Goal:	Increase by 3% the proportion of women ages 21 -44 who gets cervical screenings done.	
Definition:	Numerator:	Total number of women ages 21- 44 years received a cervical screening.
	Denominator:	Total number of women ages 21 - 44 years.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	CHC UDS, BCCP	
Significance:	Decrease cervical cancer rates.	

ESM 1.3 - Percent of Pregnant Women who has heard of the “Fight the Bite” Zika Campaign
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active	
Goal:	By 2020, decrease the percentage of pregnant women with Zika infection by 5%.	
Definition:	Numerator:	Total number of pregnant women who received a Zika prevention resource or talk during her pregnancy and prior to delivery.
	Denominator:	Number of pregnant women who received a Zika prevention resource or talk during her pregnancy and prior to delivery.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	CHC Prenatal, CHC UDS	
Significance:	Prevent women from getting the Zika virus infection that can lead to an unfavorable birth outcome.	

ESM 4.1 - Number of MCH staff attended the Certified Lactation Counselor training.

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

Measure Status:	Active	
Goal:	To increase the percent of infants who have ever been breastfed and continues until 6 months.	
Definition:	Numerator:	Number of MCH Staff who attended the Certified Lactation Counselor training.
	Denominator:	Total number of MCH Staff.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	ASMCH Title V	
Significance:	Receiving health education prior and during pregnancy can motivate mothers to breastfeed their babies. But an oncall staff who takes calls anytime to assist with mom who needs counseling and coaching through a hard time can also motivate them to keep breastfeeding.	

ESM 4.2 - Percent of women participating at the Breastfeeding Week activities who confirm they are breastfeeding.

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

Measure Status:	Active	
Goal:	Increase the number of women who are breastfeeding their infants up to 6 months of age.	
Definition:	Numerator:	Number of women participating in the Breastfeeding Week Celebration who are breast-feeding.
	Denominator:	Total number of postpartum women.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	MCH Title V Program	
Significance:	Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits. AS WIC's certified lactation consultants play a significant role in promoting breastfeeding during pregnancy and after delivery.	

ESM 4.3 - Percent of postpartum mothers reported that they received breastfeeding resources and reminders after delivery and before discharge.

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

Measure Status:	Active								
Goal:	OBJECTIVE 3.1: By May 30, 2020, increase the percent of infants who ever breastfed by 5%. OBJECTIVE 3.2. By May 30, 2020, increase the percent of infants breastfed exclusively through 6 months by 2%.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of postpartum women who reported that they received breastfeeding resources and reminders after delivery and before discharge.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of pregnant women with live births in the past year.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of postpartum women who reported that they received breastfeeding resources and reminders after delivery and before discharge.	Denominator:	Total number of pregnant women with live births in the past year.	Unit Type:	Percentage	Unit Number:	100
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Denominator:	Total number of pregnant women with live births in the past year.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	MCH Postpartum Data								
Significance:	Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits. AS WIC's certified lactation consultants play a significant role in promoting breastfeeding during pregnancy and after delivery.								

ESM 6.1 - Number of Providers utilizing a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months.

NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active	
Goal:	Increase number of medical providers utilizing a parent-completed screening tool in the past year.	
Definition:	Numerator:	Number of Providers utilizing a parent-completed screening tool in the past year to parents/guardians of children ages 9 through 35 months.
	Denominator:	Total number of providers in the Community Health Center.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Community Health Center UDS	
Significance:	This ESM will ensure that there is adequate number of medical providers in American Samoa who are confident to provide developmental screening tools for children. This will definitely increase the proportion of children who are screened early for Autism Spectrum Disorder and other Developmental Disorders and are referred to the CYSHCN program, Helping Hands and other early intervention programs.	

ESM 6.2 - Percent of clinical staff trained in the standing operating procedures for referrals to Early intervention and other programs.

NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active	
Goal:	OBJECTIVE 4.1: By 2020, increase the proportion of children (aged 10-35 months) who have been screened for developmental delays, by 10%	
Definition:	Numerator:	Number of clinical staff trained in the standing operating procedures for referrals to Early intervention and other programs.
	Denominator:	Total number of qualified clinicians that can provide a developmental screening using the ASQ at the WBCs.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	CHC UDS Data	
Significance:	With as many as 1 in 4 children at risk for developmental delay, universal early childhood screening provides an opportunity to identify delays early and intervene during the most critical period of development. Considering that standard developmental screenings may not reveal indications of autism spectrum disorder (ASD) nor social-emotional concerns, it is important to conduct ASD-specific and social-emotional screenings as well. However, approximately 40% of pediatricians do not consistently complete recommended developmental screenings.	

ESM 6.3 - Percent of participants in Children’s Oral Health awareness month activities.

NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active								
Goal:	By 2020, increase the percent of children ages 1 – 3 years who had a preventive dental visit in the past year by 25%. Strategies:								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of children ages 1-3 participating in the Oral Health awareness month activities.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of children ages 1 -3 years.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of children ages 1-3 participating in the Oral Health awareness month activities.	Denominator:	Total number of children ages 1 -3 years.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children ages 1-3 participating in the Oral Health awareness month activities.								
Denominator:	Total number of children ages 1 -3 years.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	CHC UDS Data								
Significance:	Fluoride varnish is one of the most important materials to prevent Early Childhood Cavities, it is easy to apply and well tolerated by children.								

ESM 10.1 - Percent of schools covered by Immunization School Outreach Program.

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

Measure Status:	Active								
Goal:	To increase the number of adolescents who have a preventive medical services.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of middle and high schools covered by Immunization School Outreach Program.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of middle and high schools.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of middle and high schools covered by Immunization School Outreach Program.	Denominator:	Total number of middle and high schools.	Unit Type:	Percentage	Unit Number:	100
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Denominator:	Total number of middle and high schools.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Immunization Program								
Significance:	<p>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs.</p> <p>Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults.</p> <p>The Bright Futures guidelines recommends that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health-related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.</p>								

ESM 10.2 - Number of high schools covered by Immunization School Outreach Program.

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

Measure Status:	Active								
Goal:	By 2020, increase percent of adolescents ages 12 – 14 years (6-8 grade students) with HPV vaccination coverage to 76%.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of high schools covered by Immunization School Outreach Program.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of schools.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of high schools covered by Immunization School Outreach Program.	Denominator:	Total number of schools.	Unit Type:	Percentage	Unit Number:	100
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Denominator:	Total number of schools.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Immunization Program								
Significance:	Vaccines save lives. Vaccine-preventable diseases can cause long-term illness, hospitalization, and even death. Skipping vaccines can leave you vulnerable to illnesses such as influenza (flu), pneumococcal disease, and shingles. Vaccines also protect against diseases like human papillomavirus (HPV) and hepatitis B								

ESM 11.1 - Percent of CSHCN families who received care coordination services from CSHCN staff in the past year.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active	
Goal:	Increase CYSHCN families of CYSHCN accessing their medical homes.	
Definition:	Numerator:	Number of CSHCN received care coordination from CSHCN staff in the past year.
	Denominator:	Total number of CSHCN clients.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	CSHCN survey.	
Significance:	Lack of transportation was one of the challenges hindering families from accessing their medical homes. By offering transportation means when available helps in increasing utilization and family satisfaction.	

**Form 11
Other State Data
State: American Samoa**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)