# Maternal and Child Health Services
# Title V Block Grant

# State Narrative for American Samoa

## Application for 2010
## Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

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# I. General Requirements

## A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
***An attachment is included in this section.***

## B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

## C. Assurances and Certifications

Assurances and Certifications are kept on file at the MCH office.

## D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

## E. Public Input

PUBLIC INPUT

An advisory committee was convened in order to review the Application and Needs Assessment. The Committee consists of a Health Planner, a Nutritionist and a consumer. They reviewed the plan in draft form and will continue to provide input into the plan after its submission. Their input was taken into consideration when developing the annual plan. Further, the Block Grant Application in its entirety was made available for public review. Availability of the document at the Health Department was advertised in the daily newspaper.

Beginning in 2003, the public input requirement was strengthened by providing a public viewing which was advertised well in advance in the Territory's newspaper. This public viewing takes place annually. Additionally, 3 partners to Title V conduct a thorough review and make helpful recommendations.

/2008/
The MCH Program systematically and conscientiously makes every effort to encourage consumers of program services to give voice to their concerns or suggestions regarding the quality and effectiveness of MCH Program efforts. This aspect of developing public input as a regular and ongoing process of quality assurance is especially focused on receiving input from parents and families of Children with Special Health Care Needs when MCH providers conduct their home visits. Despite continuing attempts by the MCH Program to encourage parents of CSHCN to accept staff positions in the CSHCN program, no parent has as yet accepted the invitation because of family circumstances which require parents of CSHCN to remain at home in order to fulfill the domestic responsibilities pertaining to the rest of the family.
//2008//

/2009/
An advisory council of MCH partners, stakeholders and community members was convened to review programs and services offered by the MCH Program. The most current MCH data was provided at this meeting enabling council members to review current issues and trends among the MCH population. This provided an opportunity for council and community members to voice

their concerns relevant to health and health care services currently available in the Territory. //2009//

***/2010/***
***The MCH Program has made efforts in the past to solicit public input by inviting the community and consumers to a formal review of the MCH Block Grant Application. Public participation in these reviews has not been as enthusiastic as hoped. To garner more widespread feedback and input, MCH staff have reviewed and discussed the plans with clients as a routine part of their services. Where MCH staff normally provide health education and assist with the routine Well Baby Clinics, MCH issues and priorities are discussed with families accessing services. These discussions were done informally both one on one and in groups, more as "talk story" sessions that are a familiar practice to local Samoan people. A more informal setting seemed to put people at ease and to help illicit open conversation. An issue would be introduced, followed by open ended questions on what people thought about that issue (eg: breastfeeding), what were some of the perceived barriers, what types of assistance might enable more families to participate, what activities are of interest or most helpful, and finally the activities originally proposed in the MCH plan were shared to invoke suggestions and comments to shape the final plan.***

***MCH staff also had the same types of discussions within church and community groups where time and opportunity allowed. Most if not all who participated in these discussions were family members: parents, grandparents, uncles and aunties. All comments were documented, discussed among the MCH staff, and combined to be incorporated into this year's annual plan and MCH Block Grant application.***
***//2010//***

# II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

## C. Needs Assessment Summary

In 2007 new data on adolescent health became available such as the results for the YRBS and the results of a study on the prevalence of obesity also done in collaboration with the Department of Education and the American Samoa Community College. The following data was included in the YRBS report.

TOBACCO USE
% of Total
Ever tried cigarette smoking, even one or two puffs
56.8
Smoked cigarettes on one or more of the past 30 days
24.2
Smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days 25.4

ALCOHOL USE
Had at least one drink of alcohol on one or more days during their life
46.6

Had at least one drink of alcohol on one or more of the past 30 days
29.8

SEXUAL ACTIVITY
Ever had sexual intercourse
32.0
Used a condom during last sexual intercourse
41.2
Had sexual intercourse with one or more people during the past three months
20.0

Used birth control pills to prevent pregnancy before last sexual intercourse.
3.8

DIETARY BEHAVIOR
Tried to lose weight
54.4
Ate less food, fewer calories, or foods low in fat to lose weight or to keep from gaining weight during the past 30 days
48.2

Ate fruits and vegetables five or more times per day during the past seven days 27.2

PHYSICAL ACTIVITY
Physically active for a total of at least 60 minutes per day on five or more of the past seven days
22.8

Watched three or more hours of TV on an average school day
34.9

Played on one or more sports teams during the past 12 months
64.3
American Samoa 2007 YRBS Results

The obesity study on school children from kindergarten, grades 3, 6, 9 and 12 from all schools report indicated less than 50% the students were at a healthy weight. 20% were at risk of becoming overweight, and an alarming 34% were already overweight. This was far greater than the 16% of 6-19 year olds found to be overweight in the US from 1999 - 2002. It was also substantially greater than the highest US ethnic group rate of 23.6% for 12 - 19 year old non-hispanic blacks and the 27.9% reported in Polynesian children aged 6-12 from 13 pacific countries surveyed in 2002.

The MCH program remains vigilant of the health issues facing its population and seeks new and collaborative methods to addressing these problems. The enormity of the obesity epidemic in children and adolescents has just become quantified through this newly available data. MCH will be exploring and developing plans for the coming years to meet these needs.

***/2010/***
***The 2009 the Department of Health and the Department of Education released an updated report on the obesity study of school children in American Samoa. The study did a follow up of children who were measured in the previous study to track how their height and weight (using BMI's) have changed over the last two years. The majority of students remained in the same BMI categories as the previous study however their BMI's were increasing. The proportion of healthy weight students was decreasing as the children are getting older. 56% of boys and 58% of girls who were overweight in the last study were also overweight in this study.***

***These findings point to an increased need for multi-disciplinary approached to combat obesity and overweight in the Territory. While American Samoa Department of Health has requested Technical Assistance from WHO and other regional partners on developing a strategic plan to address obesity in the overall population, MCH will continue to work with these and other partners to address the epidemic in children, adolescents and their families.***

***In 2009 the Department of Education implemented the YRBS. The study results/analysis are still pending but will be available for the 2010 Needs Assessment. The study results will be incorporated into the Needs Assessment and MCH Plan when it becomes available.***

***//2010//***

# III. State Overview

## A. Overview

The seven islands of American Samoa lie just below the Equator, approximately 2,300 miles southwest of Hawaii and 1600 miles northeast of New Zealand. American Samoa is the only United States Territory in the Southern Hemisphere. The majority of the population lives on the main island of Tutuila. Tutuila is nearly 18 miles long and just less than 3 miles wide at its widest point with a total land area of 56 square miles.

Two of the islands of American Samoa are atolls, one of which is a marine wildlife and bird sanctuary called Rose Island, and the other, Swains Island, is owned by an individual family. Swains Island is currently inhabited by less than twenty persons and is used primarily for coconut production.

The other five islands are of volcanic origin, with steep mountains rising sharply from the sea. Geologically, the island group is a chain of submerged dormant volcanoes with only the peaks rising above the ocean's surface. This topography allows for comparatively little flat land for agricultural production and for industrial, commercial and residential development. Virtually the entire population is concentrated in villages that are located along the narrow strip of flat land that fringes the coastlines of these volcanic islands. A dense tropical forest covers the mountainous interiors of the islands.

The climate of American Samoa is tropical with two distinct seasons. The first is a relatively cool dry season coinciding with the fall and winter months of the southern hemisphere, and the second is the hot, humid and rainy season coinciding with the spring and summer months (October through March). The heaviest rainfall is concentrated in the months of December through March, and the average annual rainfall is 160 inches. Summer months are also the hurricane season in American Samoa.

The total population of the Territory of American Samoa according to the 2000 Census was 57,291. American Samoa's population increased by 10,518 over the previous census in 1990, representing a 22% growth rate over the 10 year period. Most rapid growth was in Tualauta County which experienced a 50% growth in 10 years. Population estimates show that if this rate of growth remains consistent, the current mid-census population of 2005 would be 63,593. /2007/ The mid-year population estimate as of July 1, 2004 was 64,100. The current population growth rate is 2% annually and at this rate the population is estimated to reach 100,000 in 2025.//2007//

The population density of American Samoa is relatively high, about 774 people per square mile or 298 per square kilometer. This, however, is greatly intensified by the fact that the majority of the population is concentrated on less than 20 percent of the total land area of the Territory. The population of American Samoa is also relatively young with about 40% below 15 years of age. The median age for the Territory is 21.3 according to the US Census as compared to 33 for the U.S. population. In American Samoa, 5% of the total population is 60 years of age or older, compared to 16% of the US population.

/2007/ Population density for 2004 was estimated at 313 people per square kilometer. This is compared to other US affiliated islands such as Guam with 307 persons per square kilometer, the Northern Marianas with 166 persons per square kilometer, the Federated States of Micronesia with 161 persons per square kilometer, and Palau with 42 persons per square kilometer. //2007//

/2008/ The average annual number of births in the Territory is 1,700 and the average annual number of deaths is 240. The gender ratio for the total Territorial population is 104 males for every 100 females. Fully 88% of American Samoa's total population is ethnic Samoan, while the remaining 12% includes Tongans, Filipinos, Koreans, Chinese, Fijians, and Caucasians. //2008//

Statistical data showed that the percentage of the overall population actually born in the Territory had decreased in the decade between 1980 and 1990, reflecting an increase in migration. In 1980, 58.3 percent of the population was born in the Territory as compared to 54.7 percent in 1990. This trend appears to be reversing as the US 2000 Census shows that 56.7% of the population is actually born in American Samoa. A perception of the island Territory as being economically prosperous with a higher standard of living and increased work opportunities as compared to the relative lower standards of living among the neighboring island nations is largely responsible for this increase in migration.

According to the 2000 Census, 66% of the Territory's population received a high school diploma or higher. 7.4% of the Territory's population received a Bachelors Degree or higher. 97.1% of the Territory's population speak a language other than English in the home, and for almost 90% of the population, that language is Samoan.

## Social and Cultural Environment

Despite the effects of modernization and the heavy influence of materialism, the "fa'a Samoa" or the "Samoan way" still shapes daily life and remains a point of honor and cultural identity to most Samoans. Fa'a Samoa reflects a complex social order, belief system and system of conduct which have survived since ancient times. Outsiders ignorant or insensitive to the demands of fa'a Samoa can be frustrated in their efforts to conduct business or implement programs locally.

At the core of the fa'a Samoa is the "aiga", an extended family headed by a "matai" or chief. Those related by birth, adoption, or marriage are recognized as belonging to one aiga, which may include hundreds of people. One's sense of identity, happiness, welfare and economic security, in large measure, are derived from the cohesiveness and strength of the aiga.

Another important component of the fa'a Samoa is the matai system, a pyramidal organizational structure which depends on a matai as administrator of the aiga. Elevation to the position of matai is based on a combination of factors including heredity, popularity, and ability. The authority of a matai is generally unquestioned, and he is expected to assign tasks, determine kinds and amounts of donations, allocate communal land, settle disputes and bring honor to his aiga. Respect for seniors and obedience to the matai are considered primary responsibilities of all members of the aiga.

Samoan villages tend to have well defined boundaries and are composed of various aiga, each with a matai. Villages are governed by a "fono" or council composed of matai. Within a village or district the matai system extends upwards in a pyramid model to include high chiefs, high talking chiefs and paramount chiefs.

A more modern yet significant element of the prevailing social structure is the widespread adoption of Christianity. Samoans embrace Christianity and incorporated it into their traditional culture with great enthusiasm. There are churches of various denominations in most villages and Samoans spend long hours in various worship activities. The ministers or faifeau are highly influential and have a great deal of power within a community. For this reason, outreach activities to the community are often based within the context of the church.

## Economic Environment

The economy of American Samoa is highly dependent upon the United States, receiving subsidies of more than $50 million per year. American Samoans account for approximately 46 % of the overall labor force while Western Samoans account for 38%. The Territorial government employs approximately 40 percent while the two private-sector tuna processing and packing plants employ approximately 20 percent each. The minimum wage for various industries is

reviewed every two years. In 1996, minimum wages ranged from a high of $3.75 per hour to a low of $3.36 per hour for those in the fish canning and processing industry. The 2000 Census indicated that there are 9,349 households in American Samoa, 60% of which live below the poverty level. The percent of all persons qualifying for poverty status according to Federal guidelines is 60%. Moreover, greater than 90% of families below the poverty level have children under 18 years of age.

According to the US 2000 Census, the overall median family income was $18,357.

Communication

A local server offers Internet access to island residents. While many government agencies and some other organizations have begun to use the Internet as a means of accessing communication and information, its use as a means to communicate from such a remote island, is yet under-developed. At times, the local server is down for maintenance and troubleshooting for extended periods of time. The Health Department is, therefore, linked to the server at LBJ Tropical Medical Center and experiences fewer problems and "down time" as a result.

Many families on the island do not have use of a telephone. Sometimes one telephone is used as a contact number for an entire cluster of houses. Other families use the telephone at small bush stores for occasional phone calls. Many other families simply have no real need for a telephone and, therefore, rely on word of mouth, or the radio and TV for accessing information.

In recent years, a cellular telephone service opened on island. The majority of clients are government workers, government officials and business people.

/2007/
American Samoa has two major communications carriers, the American Samoa Telecommunications Authority (ASTCA) which is a semi-autonomous government agency and Blue Sky Communications, a private entity. ASTCA recently has been included in the North America Numbering Plan, which has substantially reduced the cost of long distance communications. ASTCA serves over 10,000 landlines, has become an internet service provider, and offers close to 15% of the digital cellular market. Blue Sky is primarily a digital cellular phone provider, and recently commenced operating its own Internet service. Both communications carriers offer dial up Internet connections or direct links for increased bandwidth. These advances have enabled greater telecommunications capacity to government agencies, the private sector and residential users as well. //2007//

Telehealth

In 2000, equipment was procured through funding from HRSA Office for the Advancement of Telehealth in order to facilitate health care services to the population of the outer islands of Maun'a via video conferencing. The equipment was successfully installed. However, plans to utilize the equipment were severely delayed due to technical difficulties. Title V continues to play a monitoring and coordination role for this endeavor. Partner agencies include the Department of Education and the Island's Government-affiliated telecommunications company. In 2001, Title V facilitated a number of patient consultations between clients and families with various off-island hospitals.

/2008/
Basic Social Services

Water supplies and sanitation systems are well organized and maintained, and 99% of the

population has access to safe water. Although 99% of the population has adequate excreta disposal facilities, solid waste disposal is still a problem. Waste collection systems have improved significantly, but adequate space for solid waste landfill operations is limited.

Health Status

As of the latest census in 2000, life expectancy at birth for men is 69 years, while for women it is 76 years. The crude birth rate was 27 per 1000 population in 2002, and the crude death rate was 4 per 1000 population in 2000. The infant mortality rate based on a three year average for 2004 to 2006 is 11 per 1000 live births, and the under-14 unintentional injury mortality rate is 9 per 100,000 population. The total fertility rate for women aged 15-49 years is 4.50, and the maternal mortality ratio was 123 per 100,000 live births in 2002.

Morbidity and Mortality

The morbidity pattern has shifted significantly over the past three decades. Where infectious diseases were previously the major cause of morbidity, non-communicable chronic diseases (NCDs) related to modern and lifestyle changes now predominate.

Based on the observations of senior health officers, the following are assessed as the leading communicable diseases presently affecting the Territorial population: respiratory infectious diseases, filariasis, dengue, hepatitis, tuberculosis, leprosy and intestinal worm infestations. Among NCDs, obesity, diabetes and its complications (including hypertension, heart disease and stroke), chronic disabling conditions (including asthma, gout, osteoarthritis and osteoporosis), tobacco-related obstructive pulmonary disease, cancer, and oral health are the leading causes of morbidity.

The most serious health issues are related to the increase in chronic diseases associated with lifestyle, with their roots in improper nutrition and physical inactivity. Significant increases in the prevalence of obesity, in both sexes and at increasingly younger ages, are associated with a number of these conditions. Hypertension, cardiovascular diseases, type-2 diabetes mellitus and its complications, arthritis, gout, and some forms of cancer are among these important chronic diseases.

The leading causes of mortality also show a predominance of NCDs. In the year 2000, out of a total of 224 deaths in the Territory, fully 52% were caused by heart disease, cancer, and diabetes.
//2008//

/2009/
Results from the 2007 YRBS have been released by the local Department of Education. The survey was conducted in the 6 public high schools (9-12 grades), with 3,625 students participating, a response rate of 87%. Some items of interest include indicators on tobacco use, sexual behaviors, dietary behaviors and sexual activity. From the previous YRBS report, several indicators show improvement such as tobacco use in the past 30 days.
//2009//.

Health Care Delivery System

The prevailing health care delivery system in American Samoa is organized and structured in terms of basic medical services provided to the community primarily by public sector personnel who work for public sector agencies under the watchful guidance of the Territorial government.

Until 1998, the Territorial health system was a unified, government owned and operated, centrally controlled system, which included health promotion, disease prevention, environmental protection and acute care diagnostic and treatment services. All health services were delivered through the

Health Department, which was comprised of the island's only hospital and the Division of Public Health. In 1998, the Executive Branch initiated a division between the Hospital and Public Health by creating the Hospital Authority as a separate entity within the government.

In the public sector, the Department of Health and the LBJ Tropical Medical Center are the two leading government agencies that function collaboratively to deliver comprehensive health care services in American Samoa to the entire population.

LBJ Tropical Medical Center is the only hospital in the Territory. In the past few years, a few general practice physicians have opened offices in the private sector offering evening hours. LBJ Tropical Medical Center, located on the main island, houses a pediatric clinic, OB/GYN clinic and ENT clinic, an internal medicine clinic, surgical clinic and a dental clinic, eye clinic, mental health clinic, physical therapy clinic, dialysis clinic, in addition to an emergency room which functions more like a general practice day clinic. An operating room, a multi-purpose laboratory, a diagnostic imaging department, and delivery-nursery suite are located within the hospital complex and approximately 98% of all births take place within the hospital.

/2008/
The Department of Health in American Samoa exists as an agency of the Territorial Government distinctly separate from LBJ Tropical Medical Center. The goal of the Department of Health is to provide comprehensive community-based primary care and basic preventive health services for the entire Territorial population. In addition to the MCH Program, the following list of programs and services administered by the Department of Health indicates the wide variety of preventive activities currently provided for the Territorial community: Diabetes Program, Health Education Program, Nutrition Program, Tobacco Control Program, Breast and Cervical Cancer Early Detection Program, Children's Oral Health Program, Immunization Program, HIV/AIDS Program, Bioterrorism Program, Tuberculosis Program, Hansen's Disease Clinic, STD Program, Physical Exam Clinic, Environmental Health Services, Preventive Health Services, and Early Intervention Services for Infants with Developmental Disabilities.
//2008//

Basic preventive health services including MCH activities are delivered through 5 village dispensaries, which are operated by the Department of Health. In order to eliminate disparities in access to services among disproportionately affected subpopulations and historically underserved communities, all health promotion and prevention services are offered free of charge to the public while acute care services are heavily subsidized by the American Samoa Government. The entire population of American Samoa is provided health care services regardless of ethnicity or income status. However, many other factors adversely influence access to health care:

*Remoteness of many areas of the island
*Lack of good roads in rural areas
*Lack of transportation to many rural areas.
*Cultural isolation in the case of Tongans, Western Samoans and Fijians.

There has been considerable progress in recent years towards improving access to preventive and primary care by focusing on the geographic decentralization of services provided by the Department of Health. A new federally-funded (HRSA) Community Health Center (CHC) was constructed and opened by the Department of Health in 2003.

Title V has played a monitoring role to evaluate the impact of the CHC on the MCH population. The Health Center is situated in one of the most densely populated and congested areas on the island, serving a population which is considered high risk for negative health outcomes. Accordingly, the CHC uses a Perinatal Outreach Worker in an effort to improve perinatal outcomes.

Title V operates within the overall context of the Territorial health care delivery system by providing preventive health and primary care services to the Territory's population of women, infants, children and children with special health care needs. The Title V Administrator works closely with the Director of Health and Department Health Planner as well as the Health Information System Division in order to determine the importance, magnitude, value and priority of competing factors upon the environment of health services delivery in the Territory. The Health Information System in collaboration with SSDI is currently working towards the development of a comprehensive data collection system, which will ultimately contribute to the overall health planning and resource allocation process. American Samoa is a small island Territory where collaboration is relatively easy and an increasingly close working relationship with the hospital contributes positively to the overall system of health care delivery to the population. The Title V Administrator also serves as a member of the State Child Health Insurance Program (SCHIP) Planning Committee. As such, she is able to advocate for the Title V population and provide related health status data used in the planning process for allocation of SCHIP funds.

Conclusion

The foregoing description of the physical and cultural environment in American Samoa is meant to describe the overall context in which the development of the Title V Program takes place. Oftentimes, programs are developed at the national level with certain assumptions about the political, economic and cultural environment in the respective "States." As a small island Territory in the Pacific, American Samoa offers a unique setting in which to implement an MCH program with a national emphasis. To ignore the very unique environment of the Territory overall, and the health care environment more specifically, would be an error, which would seriously compromise program success. It is the overall goal of the Health Department to develop Title V programs, which are replicable in all States and Territories, while also adapting to the very unique cultural setting found in American Samoa.

## B. Agency Capacity

Pregnant Women, Mothers and Infants

Program capacity for this population group includes well baby/well child clinics, immunization services, and pre-natal and post-partum clinics. These services are provided in the 5 dispensaries located on the main island of Tutuila and the outer islands of Manu'a. Department of Health personnel and MCH staff provide physical evaluations, conduct screenings for risk factors, and deliver health education messages on a variety of topics including nutrition, common infectious diseases, breastfeeding, family planning and healthy pregnancies. The MCH Health Educator visits the prenatal and postpartum clinics weekly to mitigate poor prenatal outcomes and to provide general counseling on a wide range of pertinent topics. Furthermore, if necessary, individualized health education is conducted on a case by case basis.

Besides providing MCH Program services in the five Department of Health village dispensaries, the Department of Health also provides MCH services in the HRSA funded Community Health Center which is centrally located in the most densely populated county of the main island. Title V leadership played a coordinating and planning role towards the development of primary health care activities in the Community Health Center. The impact of the Health Center is an increase in Title V capacity by offering high quality preventive health services to a population perennially considered at high risk for negative health outcomes.

The MCH Education Team develops health education materials for translation into Samoan. Flip charts have been produced which cover the following topics: discomforts of pregnancy, what to expect at first visit, "healthy do's and don'ts during pregnancy," and breastfeeding tips. The Team has also produced a pamphlet specifically related to prenatal care. This pamphlet is translated

into Samoan. The Nutrition Program translates health education materials into Samoan language as well. Topics include "5 a Day," breastfeeding and other general nutrition information. Radio spots concerning early prenatal care are aired in both English and Samoan. The Health Education Team also uses educational videos at the dispensaries regarding pregnancy and prenatal care. Posters and pamphlets are important teaching tools during health education campaigns and individual teaching episodes alike. Translation of effective education resources into Samoan is an important component of the services provided by Title V.

All high-risk pregnant women who are referred from other health services are provided appropriate MCH-based health education. Health education is provided in the following areas: nutrition, anemia, basic hygiene, weight control, toxemia, gestational diabetes, hypertension, breastfeeding and prenatal care. High-risk pregnant women are also referred to the other health promotional programs within the Department of Health for more targeted, specified health education. An example of this is the collaboration between Title V and the Diabetes Control Program. Women with gestational diabetes are referred directly to the Diabetes Control Program for counseling and follow-up.

Title V has also formed a linkage with the Diabetes Control Program through the involvement of the MCH Nurse Practitioner. She serves as a key member of the Diabetes Task Force and in this role has assisted in the creation of a system of care for gestational diabetics. Additionally, the MCH Nurse Practitioner serves as a member of the National Diabetes Education Program. In this role, she participates in a weekly health related news show. Gestational diabetes is included as a topic in this forum. Proper nutrition and initiation of early prenatal care are emphasized.

Public education activities include the use of mass media such as TV, radio, and newspapers to promote healthy lifestyles and to enhance awareness of maternal-child health issues, and proper nutritional practices. The MCH Women's Health Nurse Practitioner provides free health advice and promotes Prenatal care on a weekly live broadcast radio program stressing the benefits and importance of continuous prenatal care beginning in the first trimester.

The MCH Health Education and Nutrition program staff partners with the Tobacco Control Program to provide education and awareness activities on the dangers of tobacco use to prenatal mothers. Women who do report they are smoking during pregnancy can be referred to the Tobacco Control Program (Cessation Program and Quit Line) for more help. Tobacco use prevention is also included in the MCH media campaign airing on radio and public television station to target mothers and their families. MCH personnel persistently emphasize to all expectant mothers the absolute necessity for total abstinence from alcohol, cigarettes, and illicit drugs before, during, and after pregnancy.

Breastfeeding education and nutritional counseling are routinely provided by MCH personnel to all prenatal and postpartum clients at LBJ Tropical Medical Center and WIC, as well as the five village-based dispensaries and the Community Health Center. The Community Health Center staff encourages physical fitness during pregnancy and afterwards through supporting and promoting regular aerobics programs while monitoring the progress of participants by measuring weights and blood pressures and blood sugar every three months.

In the past, MCH assisted in the development of breastfeeding health education modules for the maternity ward nurses to use with women who are being discharged. Currently, the Nutrition Division staff continues to offer breastfeeding education 7 days per week in order to reach newly postpartum women. The prenatal women are reached through participation of the Nutrition staff during prenatal care clinics.

Efforts to increase the rate of mothers breastfeeding exclusively after delivery include working with the Hospital Administration and providers in the Nursery and Maternity Wards to implement the Baby Friendly Hospital Initiative. Nursery/Maternity feeding policies that address breastfeeding have been drafted and were approved in 2003. These policies also seek to ban

formula and formula paraphernalia from the hospital premises.

Hemoglobin assessments for anemia screening of children six months and older are provided during well baby and child clinics and at WIC assessments. Women are also assessed for anemia and other problems in the postpartum period at the village dispensaries.

/2008/
The majority of all pregnant women in the Territory access prenatal services at the LBJ Hospital Prenatal Care Clinic during normal day time clinic hours. In order to further expand the availability of prenatal care and reduce disparities in access to services among disproportionately affected sub-populations and historically underserved communities, MCH has made a deliberate effort to geographically decentralize the delivery of prenatal care as well as provide evening prenatal clinics for women who are unable to take time off from work to attend clinic during the day.

The MCH Nurse Practitioner offers prenatal services after normal working hours twice weekly at the LBJ Hospital and once weekly at the Community Health Center. The Community Health Center is situated in one of the most densely populated and congested areas on the main island, serving a population which is considered high risk for negative health outcomes. The Community Health Center provides day time prenatal care four days per week, while the Department of Health dispensary located in the remotest part of the main island provides prenatal care one day per week during normal working hours.

In 2006 the LBJ Tropical Medical Center implemented a financial prenatal incentive package. The package offers vouchers for free prenatal services including lab services and free two nights in the maternity ward postpartum for women who access prenatal care in the first trimester. This package was implemented as a result of poor pregnancy outcomes and poor prenatal care participation documented at the hospital. Many in the community were concerned that the recent increase in outpatient clinic fees and hospital admission rates were creating barriers to accessing prenatal care and thereby creating a negative impact on the health of mothers and babies in the Territory. The OBGYN department at the hospital has begun an awareness campaign to promote the incentive package to increase early initiation of prenatal care. The MCH program will also promote the new prenatal incentive program implemented by the LBJ Medical Authority and advise all women and families to take advantage of this program.

The MCH Program continues to collaborate with the Immunization Program and Department of Health Nursing Services to maintain immunization coverage in the community by offering free Well Baby/Child services, offering health education and public awareness on the importance of immunizations for children, and provide follow-up of children who have missed their scheduled vaccinations. MCH also provides clinicians who conduct physical assessments of all children before receiving their vaccinations, and who are also on hand in case of any adverse events. The MCH pediatrician also serves as the medical advisor to the Immunization Program for surveillance, medical consultation and planning purposes. Further, the MCH Program provides infrastructural support by providing and maintaining a database in each of the health centers that enables the nurses to look up individual records with ease, generate lists of children expected on any given date and a list of those who missed their appointments.
//2008//

/2009/
The MCH education team including the Nutrition staff visit the most heavily populated Prenatal clinics as well as the maternity ward at the hospital five days a week in order to provide health education on breastfeeding, proper nutrition, warning signs, and other topics pertinent to healthy pregnancy and infancy.

The MCH staff have also initiated a Pregnancy Risk Assessment Monitoring Survey derived from

the PRAMS survey conducted by CDC. The local survey was developed by choosing questions from the CDC PRAMS to include in the survey of local women. The key factors of interest for American Samoa are barriers to care, as the early initiation and participation in prenatal care continues to be well below the national levels, as well breastfeeding and risk factors for pregnant women. The survey is also an opportunity to evaluate the effectiveness of health education and outreach activities geared towards pregnant women.

To date, over 300 women have volunteered for the survey. The results have been tabulated and are in the process of being analyzed. The survey will continue in 2009 in order to get a representative sample size of this population.

In 2007 the MCH Program established a partnership with the Department of Human and Social Services to collaborate on the Healthy Marriages Initiative. This initiative seeks to promote healthy families by offering free courses to expectant parents. Through this partnership the MCH Program has trained 3 instructors to teach the Becoming Parents Program curriculum. The curriculum emphasizes healthy, happy parent relationships as the foundation for providing a nurturing environment for infants and children. The course teaches communication skills, anger management, time and money management, child care, and other courses to help expecting parents prepare for parenthood.

Through this partnership three Becoming Parents classes have been completed. These classes were also an opportunity for the MCH staff to present education on breastfeeding, nutrition, and other health topics. Additionally MCH staff were able to promote prenatal care and the prenatal care incentive program sponsored by the hospital. Many couples are still unaware of this program and have benefited from the Becoming Parents Program as the MCH staff helps them enroll in the financial incentive program to decrease the costs of their antenatal care.

//2009//

Children

The American Samoa Department of Health conducts well baby/child clinics in the various dispensaries; this includes the outer islands as well as the newly constructed and operational Amouli dispensary. In order to further expand Department capacity to provide well baby/child care, the MCH Program augmented its medical staff by adding an additional physician to equal 3 MCH practitioners (2 physicians and a nurse practitioner).

The Maternal and Child Health Program provides most of the resources such as supplies and staff for all dispensaries. In well baby/child clinics weight, height, and head circumference are measured. Each child is assessed for developmental status, immunized, and given a physical exam by the MCH physicians and nurse practitioners at the one-month and nine month visits. Public Health nurses assess children ages 2 months, 4 months, 6 months, and 15 months. The MCH Program is provided with adequate supplies through funds provided to the Territory by the Medicaid Program.

Client-centered health education is provided by Department of Health staff at the five dispensaries based on the specific need of each individual child. When a child comes to a dispensary with a specific complaint, the caretaker is provided with information related to the specific ailment. General information related to the child's overall growth and development is reserved for the scheduled well baby/well child visits.

The MCH Nutrition staff routinely delivers one-on-one health education with caretakers of children 1-month-old, 6 months old and 1 year old. Children are also routinely screened for hemoglobin at 6 months of age. The caretaker is given health education on the appropriate nutritional need of

the child after hemoglobin is checked. Those with results below recommended levels are referred to the MCH Practitioner for further evaluation. Children with hemoglobin levels below 11 mg/dl are given nutritional counseling and are re-assessed one month later. Those children with levels below 9 mg/dl are provided with a prescription for iron supplements and are re-assessed one month later.

MCH provides child health-related educational material on proper skin and oral care, as well as prompt immunizations. The MCH Nutrition Program, in collaboration with the WIC Program, offers nutritional education to children and others in the WIC target population. Bilingual radio spots on dental care, immunizations and the availability of parenting classes are aired regularly. Bilingual locally- produced child health related TV programs are aired as a public education effort on topics related to baby and childcare, adolescent pregnancy prevention, nutrition, breastfeeding, injury prevention, adolescent suicide prevention, and adolescent substance abuse prevention (especially tobacco, alcohol and illicit drugs).

Population-based services targeted towards children include the provision of immunization clinics as well as other outreach health education and health promotion activities. Daily immunization hours are scheduled in conjunction with well child clinics by the five dispensaries that serve the Tutuila and Manu'a population. The MCH staff will continue to coordinate services with the dispensaries and Community Health Center, Nursing services and the Immunization Program to maintain and boost the current immunization coverage level. The MCH Health Educator, who visits private day care centers throughout the Territory, will also be reinforcing the importance of immunization coverage and providing necessary information to parents and providers. Referrals to the dispensaries and Community Health Center will be made as appropriate to ensure adequate protection of young children from vaccine-preventable diseases.

Collaborative services of Early Childhood Education (DOE) and the MCH School Health Program provide full health assessments, which include dental screening for pre-school children. The Children's Oral Health Program refers children with dental problems to the LBJ Medical Center Dental Clinic for treatment. Fluoride varnish is applied for Early Childhood Education children and fissure sealants are provided for children in the third grade.

Efforts towards dental health for children are funded through Title V as well as SCHIP. Currently, SCHIP funds provide financial support for the Territorial Dental Health Initiative, which includes 4 Dental Officers (graduates from the Fiji Program), 4 dental assistants, and some essential dental equipment. In addition to the four SCHIP funded dentists, there are also currently 2 MCH dentists for a total of 6 dentists who deliver dental health services to the MCH populations. The MCH dentists generally provide preventive dental health services as well as some minor curative services when appropriate.

/2008/
The MCH Program continues to play an active role on the Teen Pregnancy Prevention Coalition each year. The Coalition is a collaborative effort between the Department of Health, LBJ Tropical Medical Center, and other community agencies to prevent teen pregnancies. The coalition works with church, youth, and community groups to promote awareness about teen pregnancy. The MCH staff collaborates with the Coalition to promote abstinence education. For example, the MCH Nurse Practitioner has a weekly radio program that allows callers to ask questions on various topics including teen reproductive health and abstinence.

The MCH Program supports all efforts to prevent teen suicide in the Territory. The Department of Health does not currently have anyone on staff specifically trained to do counseling for teen suicide, but continues to coordinate and partner with agencies and organizations that provide teen counseling and services related to teen suicide. The MCH staff partners with the Teen Suicide Prevention Coalition to provide services and connect with teens to promote self esteem, and address issues surrounding teen suicide.
//2008//

/2009/
The 2007-2008 school year was the second year of the partnership between the MCH Program and the Gear Up Program from the American Samoa Community College. The Gear Up program targets elementary students in 13 schools to prepare them for high school through after school math and English courses, sports activities, parent support activities and community based programs to support students and families. The students and families who participated in the 2007-2008 school year were in 8th grade, or children ages 13-14 years. In the coming school year, the Gear Up and MCH Programs will follow these students as they begin high school, or 9th grade.

The MCH Program has been an active partner for the Gear Up program and participants. The MCH staff visit the schools during their Wrap Around Services for parents and provide education and support on adolescent health issues including oral health, nutrition and physical activity. The MCH participated in the Gear Up summer camp to provide education and interactive activities with the students focusing on physical activity, oral health, and nutrition. It is anticipated that these efforts will be continued and followed up in the coming school year and new topics in adolescent health will be covered.

In February 2007 the MCH Program celebrated National Children's Dental Health Month. For this month the MCH Dental Team had a number of promotional activities to promote children's oral health. In strengthening the partnership between the dental team and the primary care providers, the MCH dentists shadowed the MCH pediatric providers in the Well Baby Clinics to conduct fluoride varnish for all children seen. While the dentist and physician performed the dental exam, varnish application and physical exam the dental assistant provided oral health instruction for parents and children in the waiting areas of the clinics. This was done in all 4 Well Baby Clinics. Parents were also given goody bags with toothbrushes for their children to reinforce the tooth brushing demonstration and encourage good oral hygiene.

During Children's Dental Health Month the MCH Program conducted a 3 day dental clinic open to the public to provide free dental check ups and oral health promotion. The event was advertised on the TV, newspaper and radio. As a result 340 children were served during these 3 days. Children were each given a dental exam/check-up, oral health instruction, fluoride application, and emergency treatments were done. Children were given goody bags containing toothbrushes, toothpaste, floss and a brochure on dental sealants.

Also in 2007 the MCH Dental Outreach team travelled to the remote islands of Manu'a and provided free dental services to the population on all 5 islands. 130 patients were served on this visit, the majority of those served were children. Services included health education and oral hygiene instruction, emergency treatments such as extractions and fillings as well fluoride varnish and sealant application.
//2009//

***/2010/***
***The MCH program is one of the major partners for the Gear Up Program, a cohort college prepatory program for adolescents. 2009 is the third year of this partnership that has followed a cohort of teens from 7th to 9th grade, and will continue until this cohort graduates high school. The MCH staff has been addressing adolescent health issues with this group of teens, their families and teachers. In the past two years, to coincide with current data on obesity among children and teens, MCH addressed nutrition, physical activity, and oral health. This year reproductive health was introduced as one of the new topics to the teens. The education activities emphasized knowing their bodies, how to care for and respect their bodies, and how to protect themselves against pregnancy and sexually transmitted diseases.***

***MCH will continue to work with this group of students and in 2010 topics/issues to be***

***addressed will include teen tobacco use prevention, suicide, pregnancy and STD prevention along with other topics that are already incorporated into our Gear Up Plan. The Immunization Program will join this partnership in an effort to boost immunization coverage rates among the adolescent population.***
***//2010//***

Children with Special Health Care Needs

Title V provides comprehensive assessments of those children who are screened positive for having a possible chronic or disabling condition. Most assessments are conducted in the child's home, which is less threatening and less disruptive for the family than the clinic setting. Those children with chronic and debilitating conditions, and their families, are given special support and services through the CSN Program. In all instances, the CSHCN providers encourage families to partner in decision making to maximize the families' complete satisfaction with the services they receive and are entitled to. The overall goal of the CSN Program is to encourage and empower children with special needs to live within their communities in an acceptable way and live to their fullest potential.

Occasional assessments and reviews for CSHCN are held during Well Baby Clinics. These assessments and reviews involve a holistic approach with counseling and advice on a range of issues from those relating specifically to the disability (stimulation, positioning and handling, safety) to those relating to general health (immunization, hygiene, skin and dental care).

/2008/
The CSHCN Team strives to coordinate with other agencies and service systems in the community to ensure that services for CSHCN are coordinated and comprehensive. The CSHCN staff works closely with the Early Intervention Staff, often visiting children in their homes and schools as a team. The Community Family Advocacy Group is also included in home visits with children and their families, thereby helping to avoid confusion among the parents regarding different service providers in the community.

The MCH staff continue to be active members of the Interagency Leadership Team which includes Vocational Rehabilitation, Special Education, and other service providers who are involved in school and work transitioning/ placement. The CSHCN team ensures appropriate referrals for all adolescent clients to the appropriate agencies for smooth transitions to all aspects of adult life, including adult health care. The CSHCN team facilitates transitions between pediatric and adult medical services by maintaining close working relationships with LBJ Medical staff.

The CSHCN staff work collaboratively with the Immunization Program and the Department of Health Nursing services to ensure that all children with special needs receive age appropriate immunizations. This effort is facilitated through home visits, clinic visits and referrals from other agencies. The CSHCN staff make routine visits to the health centers to check clinic records for the immunization status of children in the program. When a child is found needing an immunization, the CSHCN staff will transport the child and their family to the dispensary for the appropriate vaccinations. In cases where the child cannot come to the dispensary the nurse practitioner will administer the vaccinations at home.

The MCH dental team continues to see children with special needs at schools when they are providing school outreach services. Home visits are scheduled for those children who are not in school or who cannot be seen at school, and clinic visits will be done as needed for children who need treatments that can only be done in the clinic setting.

Other direct CSHCN services include the following options:

1. In cooperation with Special Education services of the Department of Education, assistance is rendered in developing family management plans and/or Individual Education Plans (IEP), implemented in school or at home outreach visits.
2. Advice about special management, handling techniques and equipment is provided to teachers working in special education classes and teaching CSHCN in normal school classes.
3. Certain gap filling medical treatments especially for epilepsy and muscle spasm are provided to individual patients during review assessments.
4. Regular visits are made to the respite care center in order to provide direct medical services for the severe and multiply disabled. The team members arrange referrals and facilitate access with other collaborating agencies or services to help meet particular CSN requirements.
5. Workshops are provided for parents and care givers of infants and toddlers enrolled in the Early Intervention Program on topics appropriate to their needs (hygiene, feeding, positioning, etc).

/2009/
The MCH Program has also implemented a number of outreach activities to reach families with children with special health care needs in the community. Among these activities, the MCH has conducted free clinics during Disabilities Awareness month, Disabilities Employment month, Immunization Week, and Children's Dental Health Month. During these free clinics the MCH staff provides free physical exams, dental screening, nutrition education and counseling, health education on various issues on a variety of health issues as well as goodie bags and little incentives for children. These activities are advertised and promoted in the local media and are open to the public, however special considerations are made for CSHCN clients. These children are contacted specifically inviting them to participate, transportation is provided when necessary to and from the clinic areas, with close follow-up based on their individual needs as presented at that time.

Each year the Shriners Hospital for Children in Hawaii sends a team of doctors to American Samoa provide specialty pediatric care in orthopedics, burn treatment and other pediatric surgical care. The CSHCN team works closely with the LBJ Tropical Medical Center pediatrics and surgical departments to ensure all clients who have been referred, need follow-up or who need these specialty care services are seen during these visits. The CSHCN team contacts the families to schedule time for children to attend the clinics, they work with the surgical department at the LBJ Medical center to ensure all CSHCN clients are on the appointment list, provide transportation to and from the clinics, as well as work at the surgical clinics to assist the Shriners' team. The surgical clinic is always inundated by the number of patients crowding the clinic; the additional manpower provided by the CSHCN team is always welcome to lighten the workload. This also ensures the CSHCN clients receive the services they require. The CSHCN team is also able to provide follow-up the children who require further services.
//2009//.

Finally, the MCH Program systematically and conscientiously makes every effort to encourage consumers of program services to give voice to their concerns or suggestions regarding the quality and effectiveness of MCH Program efforts. This aspect of developing public input as a regular and ongoing process of quality assurance is especially focused on receiving input from parents and families of Children with Special Health Care Needs when MCH providers conduct their home visits. Despite continuing attempts by the MCH Program to encourage parents of CSHCN to accept staff positions in the CSHCN program, no parent has as yet accepted the invitation because of family circumstances which require parents of CSHCN to remain at home in order to fulfill the domestic responsibilities pertaining to the rest of the family.

Quality of Care

American Samoa law requires that everyone is entitled to medical care at no or minimal costs.

MCH provides immunizations, well child health screening, school health and village-based screening, prenatal and post-partum care, and health education. In an effort to improve the quality of care provided to MCH populations, procedural standards and policies for immunization and nursing care services have been implemented at the dispensary level. Continuing in-service training workshops for MCH staff on well child care and immunization are conducted periodically. MCH staff also benefits from workshops conducted by the MCH Consultant, which include the development of policies and procedures for Well Baby/ Well Child Care, Prenatal Care and services to the CSN.

Additional Health Education Capacity

The Health Department is the grantee for a number of federal grant programs such as, Preventive Health Services Block Grant, HIV Prevention, Diabetes Control, TB Elimination, Tobacco Control and several others in addition to Title V: Maternal and Child Health Block Grant (MCH Block) and State Systems Development Initiative (SSDI). Each categorical program funded by federal grants generally provides its own health education efforts on the island. Health education at the village level or through use of the media tends to focus on the very specific issues of the program it is initiated by. Nevertheless, each of these federal programs increases the Health Department's overall capacity by reaching the Title V population through the health education and screening efforts specific to the individual program.
//2008//

## C. Organizational Structure

The Department of Health is one of 30 Departments in the overall Territorial Government. As such, the Director of Health serves on the Governor's cabinet and acts in an advisory role to the Governor for all matters pertaining to health issues in the Territory.

The Title V MCH Project Coordinator is placed directly under the Director of Public Health Nursing within the Community Health and Nursing Division. The MCH Program Coordinator oversees the implementation and administration of all programs with allotments under Title V, including CSHCN. The MCH Coordinator is immediately responsible for ensuring activities are implemented, monitored and evaluated, works closely with all Title V staff, and oversees the Title V reporting systems.

/2008/
Along with all other Federally funded programs in the Department of Health, the Title V Program is under the direct supervision of the Deputy Director of Health. The Deputy Director of Health, Mrs. Elizabeth Ponausuia, is the Program Director for the MCH Programs including CSHCN, MCH Information Systems and Children's Oral Health Program.
//2008//

***/2010/***
***The Department of Health is currently under a period of transition. The Department is currently under an acting director, as appointed by the governor. The acting director is still awaiting confirmation from the legislature, as he was rejected in the first confirmation hearing. Until the director is confirmed or a new director is appointed and confirmed, it is unclear what organizational changes will occur and how these changes will impact MCH services.***
***//2010//***

## D. Other MCH Capacity

Title V staff include 16 full time employees, inclusive of central office staff as well as out-stationed staff. In addition to Title V leadership, staff are organized into the following programs:

- Prenatal and Post-partum
- Well Baby
- CSHC
- Health Education
- Immunization
- Dental Health Services
- Nutrition

In addition to the above-mentioned 16 staff members who deliver services to the Territorial population of women, infants, children, and CSHCN, Title V leadership staff includes the following:

- Utoofili Aso Maga, MPH, MPA

Director, Department of Health
Mr. Maga has worked in the Department of Health for many years. He began his tenure with the Department in the Environmental Services Division. He left the island to attend the University of Hawaii at Manoa in the Master of Public Health Program. Upon his return, he served as Deputy Director of the Department until he was appointed by the Governor as Director of Health in 2005.

***/2010/***
***Mr. Utofili is no longer the Director of Health, he is currently retired.***
***//2010//***

- Ms. Tu'u Maiava, BSN, RN

Director, Community Health and Public Health Nursing
Ms. Maiava graduated from Arizona State University in 1990 with a Bachelor of Science degree in Nursing. In 1992, she returned to the Territory in order to assume the position of MCH Health Educator. She held this position for 5 years at which time she was selected as Quality Assurance and In service Specialist for Public Health Nursing. From 2003 to 2005 she served as the Director of the Tafuna Family Health Center. In 2005, she was appointed to the newly vacated position of Director of Community Health and Nursing.
/2007/ The Director of Community Health and Public Health Nursing position has been vacant since October 2005. The position is currently being advertised for suitable candidates.

* Mrs. Elizabeth Ponausuia, MPA

Deputy Director, Department of Health, Program Director -- MCH Program
Ms. Ponausuia has served the Department of Health for many years as the Chief Financial Officer. She has a Masters Degree in Public Administration and was promoted to the post of Deputy Director of Health in 2006. In this capacity she oversees all federal programs including Title V. Since the Director of Community Health and Public Health Nursing position is vacant, she continues to provide direct supervision over the Title V Program. //2007//

/2008/ The position of Director of Public Health Nursing is currently filled by Mrs. Matamuli Punimata, RN, MPH who has been with the Department of Health for many years. She previously coordinated the Health Education Program for the Department of Health. //2008//.

- Ms. Jacki Tupua Tulafono, BS

MCH Coordinator
This individual takes immediate responsibility for ensuring that all Title V activities are implemented, monitored and evaluated. She works closely with all Title V staff, oversees the Title V reporting systems and works under the direct supervision of the Director of Community Health

and Nursing. She performs continuous monitoring and evaluation functions of Title V programs and their activities.

• Nita Misi, ASN, RN
In-Service Coordinator
Ms. Misi transferred into this position in 2000. She coordinates in-service activities for all Title V staff. She acted as the coordinator of the CSN program prior to her appointment as Inservice Coordinator.
***/2010/ Ms. Misi has resigned from the Department and is now employed elsewhere.//2010//***
/2007/
* Anaise Uso, BDS
MCH Dentist, ASCOHAP Coordinator
Dr. Anaise Uso is the MCH Dentist who coordinates the MCHB funded States Oral Health Collaborative Systems project. Dr. Uso spends nine months of the year providing preventive health services to school children and spends the summer months on administrative duties relative to the SOHCS project. //2007//

/2008/
* Inoke Siasau, BDS
MCH Dentist
Dr. Inoke Siasau is an MCH Dentist who spends nine months of the year providing preventive health services to school children and spends the summer months providing outreach dental health education, and direct services to CSHCN and other dental patients served in the village dispensaries.

***/2010/***
***Dr. Siasau is now employed at the Tafuna Family Health Center. The MCH program is currently looking for replacements for this position.***

***New Staff: Dr. Olita Koria-Laititi***
***Dr. Koria has filled the vacancy for MCH Physician. Dr. Koria was hired in 2009 and is currently providing services to children who access Well Baby care at the Tafuna Family Health Center. The Tafuna Primary clinic has also hired a pediatrician who now rotates with Dr. Koria to cover both the Well Baby Clinic and the Primary Care clinic. //2010//***

Role of Parents of CSHCN on MCH Staff

The MCH Program systematically and conscientiously makes every effort to encourage consumers of program services to give voice to their concerns or suggestions regarding the quality and effectiveness of MCH Program efforts. This aspect of developing public input as a regular and ongoing process of quality assurance is especially focused on receiving input from parents and families of Children with Special Health Care Needs when MCH providers conduct their home visits. Despite continuing attempts by the MCH Program to encourage parents of CSHCN to accept staff positions in the CSHCN program, no parent has as yet accepted the invitation because of family circumstances which require parents of CSHCN to remain at home in order to fulfill the domestic responsibilities pertaining to the rest of the family.
//2008//

## E. State Agency Coordination

The following Territorial Human Service Agencies are represented in American Samoa and are all under the jurisdiction of the Territorial government:

/2008/

1. Department of Health -- the MCH Program coordinates services and activities with the following programs of the Department of Health:

a) Part C - The MCH Coordinator is a member of the interagency council for Part C. Title V staff who work with CSHCN coordinate services with Part C in the development of the Individual Family Service Plans. Part C staff provide services to the Title V population. (play therapy, assistance in the development of Individual Family Service Plans etc.)

b) Tafuna Family Health Center (Federally Qualified Health Center) -- the MCH Program coordinates with the Tafuna Family Health Center to provide Women's Health, Well Baby and Well Child, Oral Health, and Health Education services. The Health Center is situated in one of the most densely populated and congested areas on the island, serving a population which is considered high risk for negative health outcomes.

c) Immunization Program -- The MCH program partners with the Immunization program to ensure that infants and children receive age appropriate immunizations through direct services in the dispensaries as well as enabling services such as health education. Efforts are also made to combine resources towards an electronic database that will enable more effective monitoring of immunization coverage status in the community.
d) Nursing Services -- The MCH Program continues to collaborate with the Immunization Program and Nursing Services to maintain immunization coverage in the community by offering free Well Baby/Child services, offering health education and public awareness on the importance of immunizations for children, and provide follow-up of children who have missed their scheduled vaccinations. The MCH Program provides infrastructural support by providing and maintaining a database in each of the dispensaries that enables the nurses to look up individual records with ease, generate lists of children expected on any given date and a list of those who missed their appointments.

Title V staff also collaborate with the Nursing Services in the coordination and implementation of the Filariasis Elimination Mass Drug Administration Campaign. MCH staff continues to volunteer time after regular working hours to support this campaign.

e) Diabetes Control Program - Title V coordinates with the Diabetes Control Program and has assisted in the creation of a system of care for gestational diabetics. Gestational diabetes, early initiation of prenatal care, and proper nutrition are emphasized in a weekly health education show aired on public television hosted by the MCH Nurse Practitioner. Additionally, the MCH Nurse Practitioner serves as a member of the National Diabetes Education Program.
//2008//

2. American Samoa Medical Center Authority (ASMCA) -- the following divisions of ASMCA directly serve the Title V target populations:

a) The Management Information Systems works with Title V by providing opportunities for tele-health video conferencing. This enables the Title V staff to consult with off-island consultants, participate in continuing education workshop opportunities etc. Further, the Health Department is able to connect to the ASMCA Internet server in order to have continuous access to the Internet.

***/2010/***
***The MCH Program has developed a close working relationship with the Information Systems department of the ASMCA around sharing of the electronic health record. The Department of Health has a signed agreement with ASMCA to share the electronic health record to improve the quality of patient care and clinical management.***
***Access to the EHR has also been expanded to the community health centers. The next step in this project is software development enabling better collection, reporting and surveillance.***
***//2010//***

b) The OBGYN/Prenatal Care Clinic provides prenatal and postpartum care for the population of pregnant women living in the service area as well as follow up for high-risk cases which are referred to that Clinic.

c) Mental Health Services possess the ability to diagnose and administer treatment to mentally ill clients.

/2008/
d) Title XXI - Family Planning - Provides family planning services to the population of Title V. Furnishes data for MCH Program use. The MCH Program also continues to play an active role on the Teen Pregnancy Prevention Coalition each year. The coalition is a collaborative effort between the Department of Health, LBJ Tropical Medical Center, and other community agencies to prevent teen pregnancies. The coalition works with church, youth and community groups to promote awareness about teen pregnancy.

e) The ASMCA Dental Clinic and the Department of Health have a Memorandum of Understanding to provide free preventive dental services to school children whereby the LBJ Dental Clinic provides dentists and dental assistants to collaborate with MCH personnel during the school year for outreach dental services targeting 3rd grade and Head Start children in the Territory.

f) Pediatric Clinic and the Department of Health maintain a strong collaborative relationship to effectively serve the children in American Samoa by coordinating clinical and community-based services.

g) Medicaid and SCHIP - The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes at or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.
//2008//

3. Department of Human and Social Services - delivers services to the Title V population and provides necessary data items in satisfaction of federal data requirements. The following divisions of the Department directly serve the Title V population:

a) WIC - the Supplemental Feeding Program for Women, Infants and Children offers nutritional education and counseling for mother and baby, breastfeeding education, plus developmental information about babies. WIC assists the Title V Program to meet federal data reporting requirements.

b) Developmental Disabilities Planning Council - acts as a member of the interagency team focused on meeting the needs of children with special health care needs. Assists families in the development of the Individual Service Plans.

c) Division of Vocational Rehabilitation - acts as a member of the interagency team focused on meeting the requirements of adolescents with special health care needs to ensure transitional services between educational and vocational services.

/2008/

d) Teen Substance Abuse Prevention Program -- serves the adolescent population of the Territory through a community-based consortium of agencies including MCH focusing on preventing the use of alcohol and tobacco and illicit drugs among school aged teens.
//2008//

4. Department of Education -- provides the MCH Program with pertinent data from the YRBS, assists in the enforcement of the child immunization law, and assists in the coordination of the Children's Oral Health School Outreach Team as well as other school-based health education activities. The following divisions of the Department of Education directly serve the Title V population:

a) Special Education - Assists in meeting the service needs of the CSHCN population, assists in assuring that all services are provided to the CSHCN population, acts as a key member of the interagency team focused on the needs of CSHCN, assists in the development of Individual Service Plans for families of CSHCN.

b) Early Childhood Education - Assists in the enforcement of the Immunization law prohibiting children form entering school without immunization program clearance.

c) Elementary Education - assists in the enforcement of the Immunization Law prohibiting children from entering school without complete immunizations, assists families in the development of Individual Service Plans.

5. Office of Protection and Advocacy for the Disabled - assists in addressing needs of CSHCN.

/2008/
6. Center for Families of Individuals with Developmental Disabilities (CFIDD) -- The Department of Health maintains a strong collaborative relationship with CFIDD, the community family advocacy group currently active in the Territory. CFIDD personnel are also included in MCH home visits to CSHCN children and their families. This joint effort helps avoid confusion among the parents regarding different service providers in the community.

7. Interagency Leadership Council -- The MCH staff continue to be active members of the Interagency Leadership Council which includes Vocational Rehabilitation, Special Education, the University of Hawaii Center for Excellence in Developmental Disabilities, the Development Disabilities Planning Council and other service providers who are involved in school and work transitioning/placement for CSHCN.
//2008//

## F. Health Systems Capacity Indicators

**Introduction**

***/2010/***

***The process of data collection for these indicators have identified many challenges and needs in the data infrastructure. For example, it is very difficult to report on HSCI #1 because the coding of hospital admission data is not up to date. There is currently only one coder who is responsible for coding all of the information that is collected on the medical records and it is an overwhelming task to code all of the data.***

***Reporting of Medicaid and SCHIP data is also challenging as these populations are not seperated from the general population of clients served. There is no eligibility criteria, rather the population is presumed eligible and the Medicaid/SCHIP funds are awarded in bulk to the American Samoa Government and spent according to a state plan. The data reported for these measures refer to patients who received services from MCH, who are***

***not necessarily direct beneficiaries of services sponsored by Medicaid or SCHIP.***

***The MCH capacity to have an impact on these measures are reflected in the annual report on performance measures. Many of the HSCI are also addressed as performance measures such as adequacy of prenatal care, dental screening and teen use of tobacco products.***

***The MCH Program continues to partner with the Comprehensive Cancer Control Program and the Community Cancer Coaltion in developing strategies to address tobacco use in teens as well as introduction of legislation addressing exposure to second hand smoke. //2010//***

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 28.0 | 0.0 | 0.0 | 162.6 | 160.9 |
| Numerator | 24 | 0 | 0 | 143 | 152 |
| Denominator | 8576 | 8941 | 8872 | 8796 | 9445 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Notes - 2007**

Data for Year 2007 for this performance measure was not available at the time of this report. Data will be reported as soon as it becomes available.

**Narrative:**

The MCH Program continues to work with parents to keep the environment clean in the homes to reduce the number of asthma attacks in children. One key factor in the number of asthma attacks in the Territory is the presence of environmental smoke from open fires. The Samoan traditional way of cooking using open fire is still very commonly used, especially for traditional family gatherings such as Sunday family meal.

The MCH Program strives to increase public awareness about the dangers of environmental smoke exposure for young children through health education in the health centers, in the homes, and on the media (radio and TV). These efforts will continue in 2009.

Effective July 1, 2008 a law banning smoking on public transportation including buses and taxis went into effect. The law is a result of joint efforts of the community, the American Samoa Cancer Coalition, the American Samoa Environmental Protection Agency and the Department of Health. This is one of the first steps toward adoption of a Clean Air Act for American Samoa. The American Samoa Cancer Coalition, Department of Health, governmental and non-government agencies as well as community members are currently working on a draft of the bill that will be introduced. The goal is to have the Clean Air Bill introduced in January 2009 at the first session of the new legislature.

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 100.0 | 100.0 | 90.7 | 71.7 | 63.3 |
| Numerator | 1446 | 1726 | 1417 | 926 | 1315 |
| Denominator | 1446 | 1726 | 1562 | 1291 | 2078 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Notes - 2008**
The denominator for this measure is a mid-sensus estimate, and the numerator is the number of children seen by MCH in the Well Baby Clinics. There is no Medicaid eligibility criteria, therefore impossible to report for this measure.

**Notes - 2007**
This indicator does not apply to American Samoa due to its unique Medicaid program. The data reported for this measure are the number of infants screened at the Well Baby clinics. More specifically, this data was collected from only two Well Baby Clinics, Tafuna Family Health Center and CII (Central). Thus the reason for the significant drop in data reported. Data from Amouli and Leone clinics are not available at this time. Once it is available it will be reported.

**Notes - 2006**
This indicator does not apply to American Samoa due to its unique Medicaid program. The data reported for this measure are the number of infants screened at the Well Baby Clinics

**Narrative:**
The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

The data reported for this measure was derived from the Well Baby Clinics. Under the American Samoa Medicaid 100% presumed eligibility plan all children who are seen have received a Medicaid subsidized service.

The number of children reported who have been seen at Well Baby Clinic have received a physical exam from a physician or nurse practitioner, hemoglobin screening, immunizations, developmental screening, and health education on topics appropriate for age.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 100.0 | 100.0 | 90.7 | 71.7 | 63.0 |
| Numerator | 1446 | 1726 | 1417 | 926 | 1315 |
| Denominator | 1446 | 1726 | 1562 | 1291 | 2087 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | Yes | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Notes - 2008**
The denominator reported for 2008 is a mid-census population estimate for the number of infants less than 1 year of age. The numerator is the number of children seen by MCH in the Well Baby Clinics, as there is no Medicaid or SCHIP eligibility criteria.

**Notes - 2006**
This indicator does not apply to American Samoa due to its unique Medicaid program. The data reported for this measure are the number of infants screened at the Well Baby Clinics

**Narrative:**
The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

The data reported for this measure was derived from the Well Baby Clinics. Under the American Samoa Medicaid plan all children who are seen have received a Medicaid subsidized service.

The number of children reported who have been seen at Well Baby Clinic have received a physical exam from a physician or nurse practitioner, hemoglobin screening, immunizations, developmental screening, and health education on topics appropriate for age.

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 14.7 | 18.8 | 22.1 | 19.5 |
| Numerator | 0 | 73 | 103 | 96 | 225 |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | 1713 | 496 | 547 | 435 | 1153 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Notes - 2007**
Beginning with the 2007 annual report, the Pacific Basin Jurisdictions may have changed to the World Health Organization (WHO) standard rather than the Kotelchuck Index to report indicator data for HSCI04. The WHO standard recommends as essential that pregnant women make four prenatal care visits.

**Notes - 2006**
The data reported for prenatal care is for Tafuna clinic alone, not including women who access care at other clinics. The remainder of the data is in the process of being cleaned and verified.

**Narrative:**
The data reported for this indicator represents a sampling of the Tafuna Prenatal Clinic records rather than total number of live births. This data is not currently collected on the American Samoa birth certificate and therefore is not routinely reported. The data reported is manually captured from the maternity ward at the LBJ Tropical Medical Center and entered into a database at the MCH office.

A review of the data sample for 2007 reveals a slight increase in early initiation and participation in prenatal care. This may be as a result of the new financial incentive package instituted by LBJ Tropical Medical Center in 2006. In order to qualify for a discounted rate for antenatal care women must access prenatal care in the first trimester and consistently attend all scheduled visits.

The MCH Nurse Practitioners continue to provide quality prenatal services free of charge in two of the community health centers and the LBJ Tropical Medical Center. The Tafuna Clinic serves the largest population on the island as it serves the most heavily populated area (Tualauta County). All clinic visits are offered free of charge and laboratory fees are subsidized by MCH. Tafuna also offers Prenatal clinic in the evenings after normal working hours to accommodate women who work during the day. A second after hour clinic is open on the eastern side of the island twice a week to accommodate working women on that side of the island.

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 5493 | 6094 | 4972 | 4756 | 4598 |
| Denominator | 5493 | 6094 | 4972 | 4756 | 4598 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Notes - 2008**
This data is reported from children seen by MCH at the Well Child Clinics, where 100% of children are presumed Medicaid eligible.

**Notes - 2007**
The data reported are children served at the Well Baby Clinics whom are presumed 100% eligible.

**Notes - 2006**
The data reported for this measure is derived from the number of children receiving services at the Well Baby clinics. The unique nature of Medicaid and SCHIP Programs in American Samoa do not differentiate between Medicaid and non-Medicaid services.

**Narrative:**
The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 100.0 | 63.7 | 43.0 | 56.6 | 60.7 |
| Numerator | 621 | 382 | 626 | 810 | 639 |
| Denominator | 621 | 600 | 1455 | 1430 | 1053 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Notes - 2008**
The data reported for this measure reflects the number of 3rd grade children seen by the School Outreach team. There is no Medicaid/SCHIP eligibility criteria, all children are presumed eligible.

**Notes - 2006**
The data reported in this measure are children who received a dental screening from the SCHIP and MCH school dental team from the 3rd grade in the 2007 school year.

**Narrative:**
This data reflects the number of children seen by the Dental Outreach team. The data reported for this indicator represents the total number of children between 6-9 years (3rd grade) who received dental services during 2007. These children were seen at the school setting, at community outreach activities who received free dental assessments, fluoride varnish, fissure sealants, and emergency treatment as necessary.

The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 1 | 1 | 1 | 1 | 1 |
| Denominator | 1 | 1 | 1 | 1 | 1 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | Yes | Yes | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Notes - 2008**
American Samoa is not eligible for SSI, this measure does not apply.

**Notes - 2007**
This measure does not apply to American Samoa as we are not eligible for SSI.

**Notes - 2006**
This measure does not apply to American Samoa as we are not eligible for SSI.

**Narrative:**
This Indicator does not apply to American Samoa. American Samoa is not eligible for SSI.

**Health Systems Capacity Indicator 05A:** *Percent of low birth weight (< 2,500 grams)*

| INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | YEAR | DATA SOURCE | POPULATION | | |
|---|---|---|---|---|---|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of low birth weight (< 2,500 grams) | 2008 | other | 1.5 | 0 | 1.5 |

**Notes - 2010**
Vital statistics is the data source

**Narrative:**
The data reported for HSCI 5 is the same for all populations as 100% of the population is presumed eligible for Medicaid.

The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

The data reported in this field is for all low weight births.

### Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

| INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | YEAR | DATA SOURCE | POPULATION | | |
|---|---|---|---|---|---|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Infant deaths per 1,000 live births | 2008 | other | 6.7 | 0 | 6.7 |

**Notes - 2010**
Data source: vital statistics

**Narrative:**
The data reported for HSCI 5 is the same for all populations as 100% of the population is presumed eligible for Medicaid. The data reported for this measure was for all infant deaths.

The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes

art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 2008 | other | 19.5 | 0 | 19.5 |

**Notes - 2010**
Data source: MCH Data system

**Narrative:**

The data reported for HSCI 5 is the same for all populations as 100% of the population is presumed eligible for Medicaid.

The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

The data reported for this measure was the same data reported in National Performance Measure 18.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

| **INDICATOR #05** ***Comparison of health system capacity*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |

| | | | | | |
|---|---|---|---|---|---|
| ***indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | | | | | |
| Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) | 2008 | other | 19.5 | 0 | 19.5 |

**Notes - 2010**
Data source: MCH Data system

**Narrative:**

The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Infants (0 to 1) | 2008 | 100 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Infants (0 to 1) | 2008 | 100 |

**Notes - 2010**
Data source: vital statistics

**Narrative:**
The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and

Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Medicaid Children<br>(Age range 2 to 5)<br>(Age range 6 to 9)<br>(Age range 10 to 21) | 2008 | <br>100<br>100<br>100 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Medicaid Children<br>(Age range 2 to 5)<br>(Age range 6 to 9)<br>(Age range 10 to 21) | 2008 | <br>100<br>100<br>100 |

**Notes - 2010**
Data source: census estimates

**Narrative:**
The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Pregnant Women | 2008 | 100 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |

| | | |
|---|---|---|
| Pregnant Women | 2008 | 100 |

**Notes - 2010**
Data source: vital statistics

**Narrative:**
The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

| **DATABASES OR SURVEYS** | **Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)** | **Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)** |
|---|---|---|
| ANNUAL DATA LINKAGES<br>Annual linkage of infant birth and infant death certificates | 2 | Yes |
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files | 1 | No |
| Annual linkage of birth certificates and WIC eligibility files | 1 | No |
| Annual linkage of birth certificates and newborn screening files | 1 | No |
| REGISTRIES AND SURVEYS<br>Hospital discharge survey for at least 90% of in-State discharges | 1 | No |
| Annual birth defects surveillance system | 1 | No |
| Survey of recent mothers at least every two years (like | 3 | Yes |

| | | |
|---|---|---|
| PRAMS) | | |

**Notes - 2010**

**Narrative:**
The LBJ medical center has implemented an electronic health record system that allows linkage of birth and death records. The Department of Health is in the process of creating a link to that record system to enable access to vital data for program planning purposes. However because American Samoa does not have a Medicaid eligibility criteria or database it is not possible to link to Medicaid files.

WIC is administered under the Department of Human and Social Services and a data linkage with WIC has not yet been planned.

REGISTRIES AND SURVEYS
American Samoa does not have a birth defects surveillance system. The MCH program is in the process of implementing a PRAMS-like survey. All data from this survey is being captured, collected and analyzed by the MCH Program.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

| DATA SOURCES | Does your state participate in the YRBS survey? (Select 1 - 3) | Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N) |
|---|---|---|
| Youth Risk Behavior Survey (YRBS) | 3 | No |

**Notes - 2010**

**Narrative:**
The Department of Education (DOE) is the lead agency for conducting the YRBS. DOE as released the results of the survey conducted in 2007. The data reported for this measure specifically shows the number of students who reported using a tobacco product in the last month at 25.4%. This data may be attributed to the current ban on smoking in public transportation, increased efforts to ensure vendor compliance with laws regulating selling of tobacco to minors, efforts to maintain tobacco and drug free school campuses as well as increased education and tobacco use prevention activities.

# IV. Priorities, Performance and Program Activities

## A. Background and Overview

Each year, the development of this Title V application and annual report occurs over a period of several months and is representative of a collaborative effort of all MCH staff Members and leadership staff. Each health concern brought forth by MCH staff members is evaluated for the seriousness of the problem as well as the ability of Title V to impact the problem in a positive way. Each of the following 7 Performance Measures is directly correlated to each of the 7 Priority Needs.

SP1: Percent of infants born to women receiving adequate Prenatal Care according to the Kotelchuk Index.

Activities for this performance measure include a media campaign, targeted community awareness campaigns and the use of educational materials and video resources for use in the Public Health Dispensaries. Additionally, the Community Health Center will continue to use perinatal outreach workers in the Tualauta County area. The CHC will be offering an expanded prenatal care schedule, and women will continue to be offered prenatal are after working hours.

***/2010/ As services at the community health centers have expanded to include Amouli (eastern) and Leone (western) clinics, these services will be delivered in these two additional districts.//2010//***

SP2 -To increase the percent of children with special needs who have received an annual reevaluation by an interdisciplinary team.

The activities will be centered on collaborative methods to reach children where they are. This will include the CSHCN team joining the MCH Dental Outreach team in their visits to the schools so that CSHCN receive both dental and medical services in a manner that is less disruptive than physically coming to the Public Health clinics/offices.

Individual home visiting will continue, appointments will be scheduled in order to conduct comprehensive assessments in the school setting or in the Respite Care Center in order to conduct comprehensive evaluations, which include the health care provider, and the CSN Team.

SP3 -To increase the percent of 2, 3, and 4-year-old children who are seen in the MCH Well Child Clinics who access dental health services.

In 2009 the LBJ Tropical Medical Center SCHIP Dental programs have begun planning services to cater to children 0-19 years of age. The MCH Dental Outreach Team has been focused primarily on prevention, concentrating most efforts on education, fluoride application, and sealants. Through community outreach in various locations it has become apparent that many children are in need of dental treatment or curative services. Many of the children seen by the MCH Dental Outreach Team are referred for such services however few actually access services, stating one of the barriers being the cost of treatment at the LBJ Tropical Medical Center dental clinic. This has prompted discussions and plans to provide curative dental services at LBJ Tropical Medical Center dental clinic for minimal or no charge. These plans will be discussed further in 2009.

SP4 -To increase the percent of infants who attend the Well Baby Clinic who are exclusively breastfeeding at 4 months of age.

Activities for this performance measure include health education sessions promoting breastfeeding, airing radio spots and TV programs focusing on the benefits of breastfeeding, proper nutrition during breastfeeding, and helpful tips for breastfeeding mothers. Health education

materials for the dispensaries been developed and are taught by the MCH staff, with the MCH hotline included for mothers to call if they need additional assistance. Title V will partner with WIC to promote exclusive breastfeeding. Joint efforts will focus on breastfeeding education for clients and the distribution of breast pumps to mothers.

SP5 -To decrease the percent of adolescents in Grades 9-12 who report smoking cigarettes within the past 30 days.

MCH staff will continue to partner with the Gear Up program catering to children in the 9th grade in 2009 and following them through high school to address adolescent health issues such as tobacco use. MCH also maintains health education and community awareness activities on tobacco use prevention and the dangers of smoking on children.

***/2010/***
***The MCH program works closely with the Health Curriculum section of the Department of Education, Gear Up, the Comprehensive Cancer Control Program, and Taitaitama Project (substance abuse prevention) to coordinate outreach activities for teens. These activities center on teen risk behaviors such as obesity and tobacco use. //2010//***

SP6 - To decrease the percentage of 1 year olds with low hemoglobin (less than 11)

In American Samoa, hemoglobin levels are routinely checked at 6 months of age. Those children with low hemoglobin are provided counseling and iron supplementation with follow up one month later for a re-assessment.

In 2009, Title V will test 12 month olds in order to measure the impact of these interventions.

SP7 -To increase the percent of children among the children with special needs who are known to the CSN Program who receive an annual dental assessment.

The activities to address this measure will be centered on collaborative methods to reach children where they are. This will include the CSHCN team joining the MCH Dental Outreach team in their visits to the schools so that CSHCN receive both dental and medical services in a manner that is less disruptive than physically coming to the Public Health clinics/offices.

Individual home visiting will continue, including the MCH dental team in order to provide dental assessments in the homes as needed. When a child needs dental treatment that cannot be handled by the MCH dental team, where a child may need general anesthesia the child will be referred to the LBJ Dental Clinic and followed up by the MCH Dental team.

## B. State Priorities

B. State Priorities

The state priorities are specifically chosen using a wide variety of criteria. Perhaps the most important factor used by Title V in choosing the priority needs is the ability of Title V to positively impact the outcome. Title V leadership carefully weighs the magnitude of the problem as compared with the costs, both human and financial, in order to positively affect change. The priority needs, the National and or State performance measures provide a broad range of areas for Title V to concentrate its efforts.

The list of 7 state-selected priority needs are as follows:

-To increase the percent of women with a live birth who have received adequate prenatal care as determined by the Kotelchuk Index.

-To increase the percent of children with special needs who have received an annual reevaluation by an interdisciplinary team.
-To increase the percent of 2, 3, and 4-year-old children who are seen in the MCH Well Child Clinic who access dental health services.
-To increase the percent of infants who attend the Well Baby Clinic who are exclusively breastfeeding at 4 months of age.
-To decrease the percent of adolescents in Grades 9-12 who report smoking cigarettes within the past 30 days.
-To improve nutritional status of children within the first year of life
-To increase the percent of children among the children with special needs who are known to the CSN Program who receive an annual dental assessment.

After the priority needs are determined, a state performance measure with reasonable, attainable annual goals are identified only after a determination that Title V does, indeed, possess the capacity to impact the issue in a positive way. The 2005 performance measures are as follows:

SP1: Percent of infants born to women receiving adequate Prenatal Care according to the Kotelchuk Index.

SP2 -To increase the percent of children with special needs who have received an annual reevaluation by an interdisciplinary team.

SP3 -To increase the percent of 2, 3, and 4-year-old children who are seen in the MCH Well Child Clinics who access dental health services.

SP4 -To increase the percent of infants who attend the Well Baby Clinic who are exclusively breastfeeding at 4 months of age.

SP5 -To decrease the percent of adolescents in Grades 9-12 who report smoking cigarettes within the past 30 days.

SP6- To increase the percentage of 1 year olds with low hemoglobin (less than11)

SP7 -To increase the percent of children among the children with special needs who are known to the CSN Program who receive an annual dental assessment.

## C. National Performance Measures

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 0 | 0 | | 10 | 0 |
| Annual Indicator | 0.1 | 0.1 | 0.1 | 0.0 | 0.0 |
| Numerator | 1 | 1 | 1 | 0 | 0 |
| Denominator | 1713 | 1720 | 1442 | 1291 | 1338 |
| Data Source | | | | | Newborn records |
| Check this box if you cannot report the numerator because | | | Yes | Yes | Yes |

| | | | | | |
|---|---|---|---|---|---|
| 1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

**Notes - 2008**
AS does not have a state mandated newborn screening program.

**Notes - 2007**
AS does not have a state mandate newborn screening program.

**Notes - 2006**
American Samoa does not have a State mandated newborn screening program. The MCH program will review all data items currently collected that are appropriate for this measure and report them in the coming annual report.

**a. Last Year's Accomplishments**
American Samoa does not conduct newborn metabolic screening.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. This performance measure does not apply to American Samoa as there is no mandated state sponsored newborn screening programs. | | | | |
| 2. | | | | |
| 3. | | | | |
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**b. Current Activities**
American Samoa does not conduct newborn metabolic screening.

**c. Plan for the Coming Year**
American Samoa does not conduct newborn metabolic screening.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 30 | 35 | 45 | 45 | 90 |
| Annual Indicator | 35.0 | 35.0 | 35.0 | 89.3 | 89.3 |
| Numerator | 21 | 21 | 21 | 125 | 125 |
| Denominator | 60 | 60 | 60 | 140 | 140 |
| Data Source | | | | | CSHCN Program records |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 90 | 95 | 95 | 100 | 100 |

**Notes - 2008**
The data reported for 2008 is the same as 2007 as the survey to report this data has not been repeated. The Children with Special Health Care Needs Program will conduct a survey to report on this measure as an activity of the Needs Assessment due in 2010.

**Notes - 2006**
The data reported in 2006 are pre-populated with the data from the parent/family survey conducted in 2004. New data has been collected however it is not a significant enough to be representative of all children with special needs. Efforts are currently being made to collect this data for future reporting.

**a. Last Year's Accomplishments**
The data reported for this measure was reported by the CSHCN program. The CSHCN team works in a child-centered approach which necessitates the full participation of families in regards to the planning and provision of services. Services cannot be delivered without full participation of parents and families.

The CSHCN program has been able to partner with 60% of families of children with special needs in decision-making regarding health care plans. Families express their appreciation and satisfaction regarding the services provided such as assistance with travel to and from home for required appointments at the hospital, additional financial assistance with the Food Stamp program and the WIC, and also for moral support and counseling.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The CSHCN Program ensures families are involved in decision making around the services they receive and are entitled to. | | X | | |
| 2. The MCH Program continues to recruit a nurse for the CSHCN program and will continue to so until the position is filled. | | | | X |
| 3. The CSHCN Program will conduct the SLAITS-like survey in order to determine the percentage of families who are satisfied with the community service systems. | | | | X |
| 4. | | | | |

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**b. Current Activities**
Current activities include providing continuous medical home care, using standardized assessment tools and evaluations, proper referrals and cooperation with related agencies to provide necessary and appropriate services for children with special health care needs. The MCH staff have partnered with the Early Intervention staff to provide coordinated services in a family centered manner. Most services are provided in the child's home where it is less disruptive to the family.

**c. Plan for the Coming Year**
One of the most significant needs of the program is for a Nurse/Case manager. The program will continue to recruit applicants for this position in 2010. This task has been made difficult by the overall shortage of nurses in the Territory as well as the government classification system whereby Department of Health staff earn less than those who work at the hospital. Payment above the minimum will be requested for this position in an effort to fill the vacancy.

Efforts are currently being made to recruit off island for Samoan nurses who are willing to move home and work. The MCH Coordinator is working closely with the Department of Human Resources to fill this position. Efforts will also be made through the Interagency Leadership Council to recruit for and fill this position.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 0 | 0 | 98 | 65 | 90 |
| Annual Indicator | 41.5 | 54.8 | 85.7 | 89.3 | 89.3 |
| Numerator | 61 | 80 | 120 | 125 | 125 |
| Denominator | 147 | 146 | 140 | 140 | 140 |
| Data Source | | | | | CSHCN Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 90 | 90 | 93 | 93 | 94 |

**Notes - 2008**

The data reported for 2008 is the same as 2007 as the survey to report this data has not been repeated. The Children with Special Health Care Needs Program will conduct a survey to report on this measure as an activity of the Needs Assessment due in 2010.

**Notes - 2006**
The data reported in 2006 reflect the current number of children with special needs whose medical home is with served by the CSHCN program. The indicator for this year is below the target due to staffing shortages department wide. The new objectives have been set to reflect the current level of performance.

**a. Last Year's Accomplishments**
The data reported for this measure was reported by the CSHCN program. The CSHCN team works in a child-centered approach which necessitates the full participation of families in regards to the planning and provision of services. Services cannot be delivered without full participation of parents and families.

The CSHCN team has been able to provide home-visitations to 63% of its clientele. Due to lack of personnel and shared staff with other health clinics, providing coordinated medical, ongoing and comprehensive care within the home has been limited to the above percentage.

About 30% were SPED students seen annually for physical assessments within the classroom or at the CSHCN examine room. Consent forms were signed before a client was given a thorough assessment by the MCH Pediatrician and nurse. Further health care needs were discussed with parents who were present for this purpose or with an attending SPED teacher in the absence of the caregiver/parent.

In 2008, one of the two remaining CSHCN staff left the island to pursue continuing education. The Occupational Therapy Aide has enrolled in an Occupational Therapy program that will eventuate in becoming a registered Occupational Therapist and returning to work in American Samoa for the CSHCN Program.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The CSHCN staff continues to work with the other service providers such as Early Intervention, the Center forIndividuals with Developmental Disabilities, the Center for Excellence in Developmental Disabilities, the DD Planning Council, Special Educat | | | | X |
| 2. The MCH Program is an active member of the Interagency Leadership Team which coordinates planning activities for children and families with special needs. | | | | X |
| 3. The MCH team works closely with the medical services (pediatrics and internal/primary medicine) at the ASMCA to ensure clinical services are coordinated between the hospital and community. | | | | X |
| 4. The MCH program also works closely with the community health centers to ensure they are aware of CSHCN who live in their areas, their needs as well as ensuring the families know where to go should they need to access services there. | | X | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

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|---|---|---|---|---|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The CSHCN staff continues to partner with families and service agencies to ensure comprehensive and timely delivery of necessary services for CSHCN. The activities to address this measure are centered on collaborative methods to reach children where they are. This will include the CSHCN team joining the MCH Dental Outreach team in their visits to the schools so that CSHCN receive both dental and medical services in a manner that is less disruptive than physically coming to the Public Health clinics/offices.

The CSHCN team collaborates services with Helping Hands Early Intervention program for children with special health care needs from birth to 3 years, the pediatric team at LBJ Medical Center and the non-profit organization CFIDD to coordinate necessary, appropriate, and continuous medical care in the home as needed. Parents are informed of procedures, proper care and handling of child in the home. Caregivers are also given the opportunity to ask questions or share concerns regarding the care of child.

**c. Plan for the Coming Year**
The CSHCN program will continue these activities in 2010. As staffing shortage continues to be an issue for the MCH program, the CSHCN team will join efforts with other service and outreach programs such as the MCH Dental Outreach Team, the Immunization Program, Early Intervention and the Center for Families of Individuals with Developmental Disabilities in order to provide service to all CSHCN and their families.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 147 | 146 | 140 | 140 | 136 |
| Denominator | 147 | 146 | 140 | 140 | 136 |
| Data Source | | | | | CSHCN Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2006**

This measure is not applicable for American Samoa. The American Samoa law states that all residents including children receive free medical services at the government hospital and Public Health, the only two health care providers in the Territory. All children are presumed eligible for Medicaid and SCHIP services. The only cost for health care are the administrative fees charged at the hospital.

**a. Last Year's Accomplishments**

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The CSHCN Program will conduct the SLAITS-like survey in order to determine the percentage of families who are financially burdened by the services required. | | | | X |
| 2. The MCH team works closely with the medical services (pediatrics and internal/primary medicine) at the ASMCA to ensure clinical services are coordinated between the hospital and community. | | | | X |
| 3. The MCH program also works closely with the community health centers to ensure they are aware of CSHCN who live in their areas, their needs as well as ensuring the families know where to go should they need to access services there. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**c. Plan for the Coming Year**

HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be below the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes at or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 0 | 60 | 60 | 43 |
| Annual Indicator | 51.7 | 51.7 | 50.0 | 42.9 | 42.9 |
| Numerator | 31 | 31 | 30 | 60 | 60 |
| Denominator | 60 | 60 | 60 | 140 | 140 |
| Data Source | | | | | CSHCN Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 43 | 45 | 45 | 50 | 50 |

**Notes - 2008**
The data reported for 2008 is the same as 2007 as the survey to report this data has not been repeated. The Children with Special Health Care Needs Program will conduct a survey to report on this measure as an activity of the Needs Assessment due in 2010.

**Notes - 2006**
The data reported in 2006 are pre-populated with the data from the parent/family survey conducted in 2004. New data has been collected however there were not enough surveys completed to be representative of all children with special needs. Efforts are currently being made to collect this data for future reporting.

**a. Last Year's Accomplishments**
In the past year, 86% of clients within this program are able to access community-based services such as district dispensaries for immunizations, well-baby check-ups, dental appointments and health related needs. CSHCN program has also been able to team with MCH dentists to provide needed dental services together with medical home-care.

The CSHCN Program participates in community outreach programs with other agencies to increase knowledge and awareness of the public regarding children with special health care needs and the services available to them. Close partnerships have been developed with the

early intervention program Helping Hands, and the Center for Individuals with Developmental Disabilities, a community based family advocacy organization, the Pediatric Department at the American Samoa Medical Center Authority, Hope House, the local respite care facility, and the Community Health Centers.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The CSHCN Program will conduct the SLAITS-like survey in order to determine the data on the first six performance measures. | | | | X |
| 2. The CSHCN staff continues to work with the other service providers such as Early Intervention, the Center forIndividuals with Developmental Disabilities, the Center for Excellence in Developmental Disabilities, the DD Planning Council, Special Ed. | | | | X |
| 3. The MCH program also works closely with the community health centers to ensure they are aware of CSHCN who live in their areas, their needs as well as ensuring the families know where to go should they need to access services there. | | | | X |
| 4. The MCH team works closely with the medical services (pediatrics and internal/primary medicine) at the ASMCA to ensure clinical services are coordinated between the hospital and community. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The CSHCN Team strives to coordinate with other agencies and service systems in the community to ensure that services for CSHCN are coordinated and comprehensive. The CSHCN staff continues to partner with families and service agencies to ensure comprehensive and timely delivery of necessary services for CSHCN. The addition of a new physician to the CSHCN team has increased the capacity for serving children and their families. The newest team member Dr. Olita Koria works at the Tafuna Family Health Center Well Baby/Child Clinic where she provides assessments for children and their families who access services there. She also attends pediatric grand rounds to ensure she is aware of children who require special services who are either in the hospital or who may be discharged to her district.

The MCH program also worked collaboratively with the University Center for Excellence in Developmental Disabilities to co-sponsor a Related Services Training for community and family members, day care providers, special education teachers, health care providers including MCH staff and various service professionals. This three day training focused on Person-centered planning, Characteristics of Disability, early identification/child find, feeding and positioning for children with special health care needs, hospital-home transitioning, and developing/facilitating communication skills for CSHCN.

**c. Plan for the Coming Year**

The CSHCN team will continue these activities in 2010. The Program will also continue to recruit necessary staffing to ensure these services are provided. As recruitment and hiring remains a

challenge, the program will partner with the Developmental Disabilities Planning Council and the Interagency Leadership Team to hire the necessary staff for the CSHCN program.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 0 | 0 | 50 | 22 |
| Annual Indicator | 0.0 | 0.0 | 0.0 | 21.4 | 21.4 |
| Numerator | 0 | 0 | 0 | 30 | 30 |
| Denominator | 147 | 146 | 140 | 140 | 140 |
| Data Source | | | | | CSHCN Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 23 | 24 | 25 | 25 | 26 |

**Notes - 2008**
The data reported for 2008 is the same as 2007 as the survey to report this data has not been repeated. The Children with Special Health Care Needs Program will conduct a survey to report on this measure as an activity of the Needs Assessment due in 2010.

**Notes - 2006**
The data has not yet been collected for this measure. Efforts to accurately collect the number of teen CSHCN who are transitioning to adult life and services are in progress.

**a. Last Year's Accomplishments**
The MCH staff continue to be active members of the Interagency Leadership team which includes Vocational Rehabilitation, Special Education and other service providers who are involved in school and work transitioning/ placement. The CSHCN team ensures appropriate referrals for all adolescent clients to the appropriate agencies for school/work transition. The CSHCN also facilitates transition between pediatric and adult medical services by maintaining close working relationship with LBJ Medical Authority medical staff.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The CSHCN Program will conduct the SLAITS-like survey in order to determine the data on the first six performance measures. | | | | |
| 2. The MCH Program is an active member of the Interagency Leadership Team which coordinates planning activities for children and families with special needs. | | | | |

| | | | | |
|---|---|---|---|---|
| 3. The CSHCN staff continues to work with the other service providers such as Early Intervention, the Center forIndividuals with Developmental Disabilities, the Center for Excellence in Developmental Disabilities, the DD Planning Council, Special Ed. | | | | |
| 4. | | | | |
| 5. | | | | |
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**b. Current Activities**
The CSHCN will continue to work closely with hospital medical staff, Special Education, University Center for Excellence in Developmental Disabilities, the Interagency Leadership team, and Vocational Rehabilitation to facilitate and coordinate smooth transitioning for adolescent CSHCN clients.

**c. Plan for the Coming Year**
These activities will continue in the coming year. The Program will also continue to recruit necessary staffing to ensure these services are provided.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 70 | 85 | 75 | 72 | 73 |
| Annual Indicator | 79.8 | 75.1 | 70.3 | 69.7 | 68.9 |
| Numerator | 1635 | 1868 | 1684 | 1667 | 1540 |
| Denominator | 2050 | 2488 | 2396 | 2390 | 2234 |
| Data Source | | | | | Immunization Coverage Survey |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 70 | 72 | 75 | 76 | 77 |

**Notes - 2006**
There was a significant decrease in immunization coverage in 2006. This decrease is attributed to changes in the clinic hours for the Well baby clinics. The MCH and Immunization programs are cognizant of this issue and are planning changes to improve the immunization coverage.

**a. Last Year's Accomplishments**
In 2008 the Immunization Program conducted an immunization coverage survey to collect immunization data on children 1-6 years old. In this household survey, coverage rates for 19-35 month olds was at 69%. This is an alarmingly low coverage rate. Factors contributing to this decline in coverage include shortage of nursing staff, as well as changing clinic schedules. During a change in nursing administration the dispensaries changed their clinic hours, resulting in limited number of days available for Well Baby Clinics (immunization). Over the following two years the coverage rate has been on a downward trend. As a result, some clinics have reverted back to the original Well Baby Clinic schedule to accommodate the number of children who needed to access care. However, this reactive measure has not entirely resolved this issue in the two larger clinics.

One of the accomplishments towards this measure was completion of the household coverage survey. The survey summary/results provided validated data, but along with the summary, a roster of delinquent children was generated for each clinic to enable clinic staff to follow those children up for catch up appointments. Other important information on these children was also collected, including contact information, the number of children in each age group attending day care or school, and other demographic information. It is anticipated that activities in the next project year will address this issue resulting in an upward climb of coverage rates.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The MCH Program will work closely with the Immunization program and the day cares and Head Start to ensure children served are current with their vaccinations. | | X | | |
| 2. The Immunization and MCH programs collaborate on activities such as posting billboards, posters and pamphlets | | X | | |
| 3. Media coverage on the importance of childhood immunizations includes radio spots, TV shows and spots on the evening news | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
A new development towards this Performance Measure is the collocating of WIC staff to the (3) community health centers. WIC is administered under a different agency (Department of Human and Social Services) and was previously located at one central location. In 2009, coinciding with the community health center expansion from just the Tafuna Family Health Center to include the two furthest outlying clinics to the east and west of the island, the WIC agency has agreed to collocate services with the community health centers. WIC services can now be accessed at the same location as the Well Baby and Prenatal Clinics. Health assessments are part of the WIC intake process, and it is anticipated this new development will improve immunization coverage by improving accessibility of Well Baby Clinic services to the WIC clients.

The MCH Program continues to collaborate with the Immunization Program and Nursing Services to maintain immunization coverage in the community by offering free Well Baby/Child services. MCH also provides clinicians who conduct physical assessments of all children before receiving

their vaccinations, and who are also on hand in case of any adverse events. The MCH Program provides infrastructural support by providing and maintaining a database in each of the health centers that enables staff to look up records, generate lists of children expected on any given date and generate a list of those who missed their appointments.

**c. Plan for the Coming Year**

The MCH and Immunization Programs developed collaborative plans to mitigate this issue. The Immunization Program is currently in the process of hiring more staff to accommodate the increased work load, to include a School Health Nurse and a Hepatitis Nurse. Joint plans include implementing a joint school outreach team that will include both MCH and Immunization program staff. The efforts of the team will include providing immunization and preventive dental services to school children in a coordinated effort.

Other plans for this measure include community outreach activities, catch up clinics, mass media campaigns, and coordinating efforts with other agencies such as WIC, Head Start, and other interdisciplinary public and private sector organizations. The Immunization Program has also applied for funding for a mobile health unit to facilitate outreach clinics in order to boost Immunization levels among families, and not just one age group.

Like the MCH Program, one of the biggest challenges faced by the Immunization Program is staffing. Nurses are in very short supply, contributing to congestion at the Well Baby Clinics, and the overall low coverage rates. The Immunization Program is also struggling to recruit and hire staffing for this project, and has plans to recruit retired and off duty nurses who are willing to work after hours and weekends to conduct community outreach (catch up clinics).

The MCH staff will continue to coordinate services with the community health centers, nursing services, and the Immunization Program to maintain and boost the current immunization coverage level. The MCH Health educator who visits the day care centers will also be reinforcing the importance of immunization coverage and providing necessary information to parents and providers. Referrals to the health centers will be made as appropriate to ensure adequate protection of young children from vaccine preventable diseases.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 22 | 21 | 20 | 11 | 10 |
| Annual Indicator | 22.0 | 11.7 | 11.0 | 14.8 | 15.6 |
| Numerator | 38 | 22 | 33 | 27 | 29 |
| Denominator | 1727 | 1883 | 2990 | 1828 | 1856 |
| Data Source | | | | | Vital Statistics |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 14 | 14 | 12 | 12 | 11 |

**Notes - 2006**
The increase in the denominator for this measure is a population estimate from the office of Vital Statistics. This MCH program staff will inquire about the significant difference from 2005-2006, however for the time being data for both years is reported as provisional.

**a. Last Year's Accomplishments**
The MCH Program continues to play an active role on the Teen Pregnancy Prevention Coalition each year. The coalition is a collaborative effort between the Department of Health, AS Medical Center Authority, and other community agencies to prevent teen pregnancies. The coalition works with church, youth and community groups to promote awareness about teen pregnancy.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The MCH staff will collaborate with the Teen Pregnancy Prevention coalition to promote parents talking to their teens about sexual behaviors. education. | | X | | |
| 2. The MCH Nurse Practitioner provides family planning services that also serve teens seeking education and contraception. | X | | | |
| 3. The MCH Women's Health Nurse Practitioner has a weekly radio program that allows callers to ask questions on various topics including teen reproductive health and abstinence. | X | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The MCH Program provides free health education, counseling and reproductive health services to the community in the four health centers and the American Samoa Medical Center Authority. These services are offered to teens and their families during regular working hours and expanded clinic hours in the evenings.

The MCH program has is one of the major partners for the Gear Up Program, a cohort college prepatory program for adolescents. 2009 is the third year of this partnership that has followed a cohort of teens from 7th to 9th grade, and will continue until this cohort graduates high school. The MCH staff has been addressing adolescent health issues with this group of teens, their families and teachers. This year reproductive health was introduced as one of the topics to the teens. The education activities emphasized knowing their bodies, how to care for and respect their bodies, and how to protect themselves against pregnancy and sexually transmitted diseases.

**c. Plan for the Coming Year**
The MCH Program will continue to partner with Gear Up to address adolescent health issues including teen pregnancy/sexual activity. The MCH Program had the opportunity to present at the Gear Up Summer Camp, and will plan more activities for the next coming school year. With the expansion of school health services in the 2009-2010 school year, there will be more opportunities to address these issues with teens. MCH will continue to provide interactive

educational activities for teens through Gear Up and other outreach events.

One of the issues teens identified was difficulty talking to their parents about issues such as teen pregnancy or anything related to sex. The MCH staff acknowledges these difficulties and will be working with teens, parents and community members to overcome this barrier. This is a very sensitive issue, therefore strategies will be developed to address it in a culturally sensitive manner that is developed collaboratively with both teens and their parents.

Technical assistance in adolescent health has been requested both in this application and from the Secretariat of the Pacific Community Public Health Division in order to better address adolescent health issues.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 55 | 35 | 25 | 32 | 45 |
| Annual Indicator | 20.8 | 4.2 | 41.9 | 44.1 | 60.7 |
| Numerator | 234 | 72 | 609 | 631 | 639 |
| Denominator | 1127 | 1699 | 1455 | 1430 | 1053 |
| Data Source | | | | | MCH School Outreach Data |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 45 | 50 | 50 | 52 | 54 |

**a. Last Year's Accomplishments**
Last year's Annual Indicator had significantly increased from 44.1% to 60.7%. A total number of 639 third grade students had at least one permanent molar sealed. By the end of May 2008, the total number of third grade students in the Department of Education's school enrollment was 1053 students. The Dental Outreach Team was again a joint effort between the SCHIP dental team (from the AS Medical Center Authority Dental Services) and that of MCH. A total staff of 6 was assigned to this outreach program. It consisted of three dentists (2 from MCH) and three dental assistants (1 from MCH).

The Dental Outreach team was able to visit 21 elementary schools territorial-wide. The number of days the team remained in these schools ranged from 2 days to four weeks. Traveling time to schools varied from 5 minutes to an hour, using the MCH vehicle and the SCHIP van. Towards the middle of the year, the SCHIP van was out of service and thus some of the staff had to use their own personal vehicles, which was a slight barrier.

Third grade was the main target but students from other grades were seen as well if parents requested help to alleviate their child's pain from a toothache. Primary preventive dental services provided included placement of protective fissure sealants, fluoride varnish application, tooth

brushing demonstration and dispensing of free toothbrushes. Dental restorations and extractions were also provided to alleviate pain. Every child was given a dental report card to inform parents and/or caregiver about their dental status. It also informs them of any need for further treatment. The MCH program provided fluoride varnish and sealant supplies, as well as incentives during each dental health education. Incentives included toothbrushes, floss and stickers.

In May 2008, a Sealant Evaluation report was completed by the MCH Dental Team. It reported 62% sealant retention. Each member of the outreach team, including dental assistants, has been placing these sealants. To maintain and/or improve this retention rate, dentists recheck all sealants placed by dental assistants to ensure retention.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The MCH Dentists work with the Department of Education to provide preventive dental services to school children on site free of charge. | | | X | |
| 2. The MCH multimedia campaign will include public service announcements on fissure sealants and nutrition to promote oral health. | | X | | |
| 3. The MCH Dental team has developed educational pamphlets and materials that will be distributed at community outreach activities. | | X | | |
| 4. The MCH Dental team provides free preventive dental services for children during Children's Dental Health Month as an annual promotional activity. | X | | | |
| 5. The MCH dental team will be conducting screening of fourth graders for fissure sealant retention. | X | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

As of present, a total number of 345 third grade students have a dental sealant present on at least one permanent molar. This data should be doubled by the end of the school year. A total number of 12 elementary schools were covered out of a total of 31 schools. In February, the school outreach team experienced a shortage of supplies, and had to suspend the sealant services while supplies were on order. While the team was waiting for supplies, they carried out sealant retention survey as well as providing dental screening for CSN high school students at the CSN office.

In February 2009, for the Children Dental Health Month, the dental team concentrated more on giving oral health presentations to third grade students (7 elementary schools) as well as 9th grade students (Gear-Up). A total number of 184 Gear-up 8th grade students were screened, and given report cards to take home, notifying parents and care-givers of their oral conditions as well as informing them of the need to visit the nearest dental clinic for further tests and treatment as warranted.

One of the MCH dentist and the only dental assistant left the program to work at the Tafuna Family Health Center dental clinic. This leaves one remaining dentist. The MCH program will focus on recruitment and hiring of new staff before the beginning of the new school year.

**c. Plan for the Coming Year**
The dental team will continue to provide services to children in the elementary levels. The team will also be joining the CSHCN and Immunization staff to provide preventive health services to school aged children. It is anticipated that combining staff and other resources will enable both programs to provide more comprehensive services. As time and staffing allow, the MCH dental outreach team will participate in outreach activities in conjunction with the Immunization program in order to provide dental services to more children.

MCH program will focus on recruitment and hiring of new staff before the beginning of the new school year. This remains a challenge as all of the dentists on island are currently already employed by the AS Medical Center Authority, as an authority the hospital offers a higher pay scale than does the Department of Health making it difficult to recruit to fill the current vacancies. The MCH program is exploring recruiting from the neighboring islands to fill these positions.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 5 | 6 | 6 | 4 | 4 |
| Annual Indicator | 7.1 | 0.0 | 4.4 | 3.8 | 0.0 |
| Numerator | 5 | 0 | 1 | 1 | 0 |
| Denominator | 70391 | 23487 | 22720 | 26444 | 25783 |
| Data Source | | | | | Vital Statistics |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 3 | 3 | 2 | 2 | 2 |

**a. Last Year's Accomplishments**
There were no reported motor vehicle deaths reported in 2008. This performance measure is impacted by the very low speed limit of 25 miles per hour in the Territory, as well as enforcement of the limits. The Territory has seen an increase in the number of vehicles on the road and speeding has been hindered with added congestion on the roadways.

Vehicle safety has been included as one of the safety topics in the Well Baby Clinic education modules and is reinforced by the health education staff.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The MCH health education staff will partner with the Department of Public Safety and EMSC to include vehicle safety | | X | | |

| | | | | |
|---|---|---|---|---|
| in existing health education activities. | | | | |
| 2. The MCH health education and Nutrition staff will continue partnership with Daycare centers to provide proper vehicle safety education to the Daycare Centers. | | X | | |
| 3. Motor vehicle safety is a topic covered by the health education modules of the Well Baby Clinic. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
MCH will continue to promote vehicular safety through education at the community health centers, the day care centers and through the media. The MCH Program is also partnering with the Office of Highway Safety to strengthen data capacity for this measure, focusing on reporting measures in place for highway accidents that will shape intervention efforts.

**c. Plan for the Coming Year**
The MCH staff will partner with the Office of Highway Safety and the EMSC program to promote child safety and vehicular safety in the community. In a partnership with the Office of Highway safety, the MCH Program will be expanding data collection activities to the community health centers and village dispensaries as well as increase public awareness on child vehicle safety through media/public service announcements.

The MCH Program will also be partnering with the Office of Highway safety to implement a child restraint promotion program. The Office of Highway safety will provide technical assistance to MCH staff in order to provide education to parents on appropriate use of car/booster seats. Through this partnership, families will be able to attain car seats for no cost while ensuring parents participate in a vehicular safety education program. It is anticipated this project will be incorporated into routine prenatal and well baby/child clinic services.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 35 | 36 | 36 |
| Annual Indicator | | 35.4 | 34.2 | | 45.0 |
| Numerator | | 585 | 675 | | 605 |
| Denominator | | 1652 | 1973 | | 1345 |
| Data Source | | | | | Well Baby clinic Data |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3- | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 37 | 37 | 38 | 39 | 40 |

**Notes - 2007**
The data reported for this measure in 2007 reflects data collected from the two largest Well Baby Clinics. Data has not been collected from the two smaller clinics at the time of this report. This data will be corrected once it has been analyzed.

**a. Last Year's Accomplishments**
In FY 2OO8, the MCH Program continued efforts in order to lay a solid foundation of education and information on breastfeeding during the prenatal period in order to help mothers choose breastfeeding as a feeding method. The MCH Program continued to make breastfeeding a priority area in its health education efforts at the community level as well.

The MCH Staff incorporated breastfeeding education within 24 hours after delivery. The rooming-in policy allows new mothers to have full access to their newborns, and breastfeeding counseling is provided on the first day of the postpartum stay in the hospital. Free breast pumps are also available at WIC, and for mothers with premature or sick babies at the nursery to utilize in expressing breast milk for their infant.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide health education on breastfeeding to women attending prenatal clinics in the community health centers and the American Samoa Medical Center Authority OBGYN clinic. | | X | | |
| 2. Continue to air public service announcements on the benefits of breastfeeding and colostrum on local radio stations. | | X | | |
| 3. Continue to provide breastfeeding coaching and counseling to postpartum mothers at the Maternity Ward at American Samoa Medical Center Authority. | | X | | |
| 4. Continue to provide education and breastfeeding tips to mothers attending Well Baby Clinic at the community health centers. | | X | | |
| 5. Develop a breastfeeding plan to be used as a guide for women to prepare for breastfeeding during the prenatal period. | | | | X |
| 6. Recruit breastfeeding mentors in the community to offer breastfeeding support to mothers at home. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The MCH staff continue breastfeeding education and counseling to women accessing prenatal care in all of the community health centers as well as the OBGYN clinic. One on one counseling is also conducted at the Maternity Ward post delivery. The MCH staff are on hand to provide support and coaching for mothers who need help with breastfeeding initiation. The MCH hotline telephone number is also given out for mothers to call if they need additional support at home. Breastfeeding is one of the nutritional topics covered in education and counseling at the well baby clinics for mothers who are bringing in their infants or toddlers in for a Well Baby Clinic visit.

Breastfeeding radio spots air continuously on the local radio stations throughout the year. The MCH staff also broadcast television shows on breastfeeding.

**c. Plan for the Coming Year**

The MCH staff plan to conduct focus groups, and some informal information gathering discussions with women in their last trimester or within 6 months of delivery in order to ascertain their knowledge and practices around breastfeeding. Although breastfeeding is continuously promoted through education and mass media, the secondary audiences for this information have not been identified. Most of the information has been traditionally focused on the mothers, however those who are involved in the decision making process need to be included as well. With this information, the approaches and activities used to promote breastfeeding can be fine tuned and more focused.

The MCH staff plan to develop or adopt a framework breastfeeding plan for prenatal and post-partum mothers to be used as a guide to help reinforce their plans for breastfeeding. Similar to a birthing plan, the idea is to help women prepare for breastfeeding prior to delivery to ensure greater success. The plan will include helpful tips and educational material, from positioning and nipple care to including fathers and other family members in the feeding plan. Often mothers are not prepared for the demands and challenges of breastfeeding and often are not able to overcome barriers. The breastfeeding plan will help women anticipate challenges and decide with her partner and family how to address those challenges, with guidance and assistance provided by MCH staff both prenatally and postpartum. The guide will also contain contact information and resources where they can find help.

Finally, the MCH Program plans to develop a breastfeeding support network of women in the community, church groups who are interested and willing to be breastfeeding mentors in their communities. One of the barriers to breastfeeding women have identified is the lack of support at home. To address this need the MCH program plans to develop partnerships with women in the community who can provide breastfeeding support in the homes. The MCH staff will provide training, coordination, and technical support and follow up for the mentors. This will be a pilot project in 2010, and begin with 3 church groups. This group can also be solicited to provide feedback and be involved in the development of a breastfeeding plan.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |
| Annual Indicator | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 0 | 0 | 0 | 0 |
| Denominator | 1713 | 1720 | 1442 | 1291 | 1338 |
| Data Source | | | | | No Data source |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average | | | Yes | | |

| | | | | | |
|---|---|---|---|---|---|
| cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 30 | 35 | 40 | 45 | 50 |

**Notes - 2008**
AS does not have a hearing screening program.

**Notes - 2006**
Hearing screening is not available in American Samoa .

**a. Last Year's Accomplishments**
American Samoa does not conduct hearing newborn screening, this measure is inapplicable.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The MCH program will work closely with the early intervention program in providing the initial screening and follow up. | X | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
In 2009 the Department of Health was awarded a newborn screening grant and began screening in the beginning of the year. Currently the early intervention staff is providing the screening and follow-up as this new project also provides technical support by a team of audiologists from off island. This measure will be reported in the 2010 application.

**c. Plan for the Coming Year**
The MCH Program will continue to partner with the early intervention Helping Hands program to provide services to infants and their families. The CSHCN staff routinely work with the Helping Hands staff to follow up children with special health care needs, and will continue to do so in 2010.

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |
| Annual Indicator | NaN | NaN | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 0 | 0 | 0 | 0 |
| Denominator | 0 | 0 | 22720 | 26444 | 26863 |
| Data Source | | | | | Census Estimates |

| | | | | | |
|---|---|---|---|---|---|
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | Yes | Yes | Yes |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

**Notes - 2008**
This measure is not applicable for American Samoa. The American Samoa law states that all residents including children receive free medical services at the government hospital and Public Health, the only two health care providers in the Territory. All children are presumed eligible for Medicaid and SCHIP services. The only cost for health
care are the administrative fees charged at the hospital.

**Notes - 2007**
This measure is not applicable for American Samoa. The American Samoa law states that all residents including children receive free medical services at the government hospital and Public Health, the only two health care providers in the Territory. All children are presumed eligible for Medicaid and SCHIP services. The only cost for health
care are the administrative fees charged at the hospital.

**Notes - 2006**
The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**a. Last Year's Accomplishments**
HEALTH INSURANCE DATA DOES NOT APPLY TO AMERICAN SAMOA. The American Samoa Medicaid and SCHIP programs do not determine individual eligibility or enroll individuals. Rather, the proportion of the entire population known to be blow the poverty level is presumed eligible and the cost of providing Medicaid services to this population is used to determine the Medicaid share of the program (50/50). Over 56% of the population have incomes art or below the federal poverty level. Because the American Samoa Government provides all health care services at little or no cost, everyone, including low income individuals and families have access to essential services. The federal share is reimbursed to the hospital and Department of Health directly to help subsidize the cost of these services. American Samoa opted to implement SCHIP as an extension of its Medicaid Program; all children are eligible for SCHIP services.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. This measure not applicable to AS. | | | | |
| 2. | | | | |

| | | | | |
|---|---|---|---|---|
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
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| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
This measure does not apply to American Samoa.

**c. Plan for the Coming Year**
This measure does not apply to American Samoa.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 50 | 50 | 14 |
| Annual Indicator | | 0.0 | 0.0 | 14.0 | 14.3 |
| Numerator | | 0 | 0 | 1230 | 1053 |
| Denominator | | 2031 | 3341 | 8791 | 7358 |
| Data Source | | | | | Well Baby database |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 14 | 13 | 13 | 12 | 12 |

**Notes - 2007**
The data reported for this measure is of the children served at the Well Baby Clinics as WIC is unable to extract this data from the current WIC database.

**a. Last Year's Accomplishments**
The MCH Program is currently reporting this data from the Well Baby Clinics, of those children who participate in WIC.

In FY 2008, the total patients screened with Hemoglobin from ages 6 months to 4 years old are 72. These nutrition counseling sessions are done individually and priority is set to reflect client's need with recommended solutions. The MCH Staff utilizes the "SOAP" method in the client's folders to ensure follow-up in clients care.

In FY 2008, the MCH Program celebrated National Nutrition Month. For this month the MCH Program had a number of promotional activities to promote children's health. The MCH Program

conducted a poster and recipe competition to elementary school both government and private participated. The event was advertised on the TV, newspaper and radio. As a result 116 children were participated during these activities. Other activities were carried out to promote nutrition among children in general, such as carrying out a health education in the Well Baby Clinic in which children's health was promoted.

Radio spots continued to air on promotion of infant and young child feeding with a number to call if there are any questions. TV programs continue to air discussing the importance of nutrition.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue to provide nutrition education and counseling to families at Well Baby/Child clinics. | | X | | |
| 2. Conduct assessment of health communication methods. | | | | X |
| 3. Conduct focus groups to ascertain from parents and caregivers types of activities that are most helpful to them. | | | | X |
| 4. Revise Well Baby Clinic education modules based on information gathered. | | | | X |
| 5. Provide inservice on children's BMI, child groth and development and early childhood nutrition for all MCH service providers. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The MCH Program offers nutrition education and counseling for parents and care givers at the well baby clinics, at the day cares and through public service announcements. Posters and pamphlets have been distributed and posted to all health centers and other public places to increase awareness about healthy nutrition. These materials have been adapted to feature local foods, both good and bad and materials have also been translated.

In April 2009 MCH staff participated in a Wellness Fair, planned and implemented in partnership with DOE, Community Natural Resources (community college), the Community Cancer Coalition, the Teen Substance Abuse Prevention Project and various other partners. The Wellness Fair aimed to provide fun, learning activities for children and their families to promote health and wellness.

The MCH staff set up 3 booths, including booths on nutrition and physical activity. Kid friendly learning activities on nutrition and physical activity were implemented. Over 300 people participated in these activities. A follow up fair is being planned for next year.

**c. Plan for the Coming Year**

As education and public awareness are the larger parts of this performance measure, the MCH program plans to conduct an assessment of the methods of education and communication used for childhood nutrition. This is to find out what families are learning from the current communication methods, confirm which methods are most effective for our population and also to find out who primary and secondary audiences for this information really is. Those who are responsible for feeding and meal preparation for the children need to be targeted, and they may

not be the parents or those who are currently being targeted.

Concurrently, continuing education on child BMI, growth and development is a continuing need for MCH and for nursing staff as well. Training and continuing education will be provided on these topics in 2010, to strengthen skills and competencies among service providers for children. This will begin with Public Health staff first, and hopefully expanded to other service providers such as day cares. A third activity will be to review and revise the Well Baby Clinic education modules to address this issue, and staff inservice on the correct usage of the modules.

The MCH Program has also been involved in plans for developing a non-communicable disease strategic plan for American Samoa. The Department of Health is partnering with WHO and the Public Health Division of the Secretariat of the Pacific Community to develop this plan, based on a WHO framework. The MCH Coordinator is currently working with representatives from both WHO and SPC to ensure that children and their families are included in this framework and its subsequent implementation.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 20 | 20 | 10 |
| Annual Indicator | | 0.0 | 2.1 | 3.3 | 2.5 |
| Numerator | | 0 | 30 | 10 | 8 |
| Denominator | | 1720 | 1442 | 300 | 314 |
| Data Source | | | | | PRAMS-like survey |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 7 | 5 | 3 | 2 | 1 |

**Notes - 2006**
This data reported for this measure was collected from the pregnancy risk assessment survey started in May 2007. This data is not representative of all women who were pregnant as this data was only collected over a short period of time therefore the target for this measure will not be changed until more reliable data is available.

**a. Last Year's Accomplishments**
The MCH Program implemented a pregnancy risk assessment survey, based on the CDC PRAMS survey in 2008. A sample of 400 women was surveyed out of approximately 1200 live births, and of those only 28 women reported smoking during the last trimester of pregnancy. Although this is a very low number, MCH staff continue to address the dangers and effects of smoking on both mother and baby at prenatal clinics. The MCH health educator is a certified cessation facilitator and is trained to provide cessation support for any women who need or request cessation classes.

The Tobacco Control Program also support this measure through education and awareness

activities. This includes a weekly radio program on the dangers of tobacco, that enables listeners to call in and ask questions. There is also a Smoking Quitline that provides support for anyone interested in quiting or smoking cessation.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The MCH Health Education and Nutrition program staff will partner with the Tobacco Control Program to provide education and awareness activities on the dangers of tobacco use to prenatal mothers. | | X | | |
| 2. Tobacco use prevention will also be included in the media campaign currently airing on the radio and public television station to target mothers and their families. | | X | | |
| 3. | | | | |
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| 5. | | | | |
| 6. | | | | |
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| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The MCH staff provides education on risk behaviors during pregnancy to all prenatal women. Women who do report they are smoking during pregnancy can be referred to the Tobacco Program (Cessation Program and Quit Line) for additional services.

**c. Plan for the Coming Year**

The MCH Program will continue to address smoking during pregnancy in the prenatal, post partum, and
Well Baby clinics and in public service announcements. The MCH Program will also continue to work closely with the Comprehensive Cancer Control Program and the Community Cancer Coalition to reintroduce a Clean Air bill into the local legislature to provide and enforce smoke free environments for all.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Performance Objective | 43 | 41 | 40 | 40 | 39 |
| Annual Indicator | 41.5 | 0.0 | 0.0 | 0.0 | 0.0 |
| Numerator | 7 | 0 | 0 | 0 | 0 |
| Denominator | 16857 | 5223 | 5430 | 5320 | 6317 |
| Data Source | | | | | Vital Statistics |
| Check this box if you cannot report the numerator because | | | Yes | Yes | Yes |

| | | | | | |
|---|---|---|---|---|---|
| 1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 15 | 15 | 13 | 12 | 12 |

**Notes - 2008**
There were no events reported for this measure.

**Notes - 2007**
There were no events reported for this measure.

**Notes - 2006**
Reporting for this measure has changed in from 2004 to 2005 and 2006. Previously (as in 2004) the data was reported in three year moving sums because that was how it had been reported since 2001. In 2005 the data were reported in 3 year moving averages, therefore there appears to be a significant decrease in the total number reported. This decrease is the differnce between previous reporting practices of using a three sum versus using a three year average.

**a. Last Year's Accomplishments**
The MCH Program continues efforts to coordinate with other programs and agencies that provide counseling and other services related to teen suicide. Of late, there has been a decline in the incidence of teen suicide in American Samoa. This may be attributed to the increase in teen/youth involvement programs, from church activities, sports activities, and the recent development of a strategic prevention coalition in the community to prevent substance abuse, and an active child abuse prevention coalition.

The MCH program is an active partner in many of these organizations and activities. The MCH staff participates in teen coalitions and community outreach activities geared towards youth/ teens. Teen suicides have been at a decline and therefore more pressing issues such as reproductive health, substance abuse, and obesity have taken more of the focus of efforts in adolescent health.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The MCH staff will partner with the Teen Suicide Prevention coalition to coordinate suicide preventon services. | | | | X |
| 2. The MCH staff will partner with other agencies and programs which provide services to teens to promote self esteem, and address issues surrounding teen suicide. | | X | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
MCH continues to partner with Gear Up, a cohort college prepatory program for adolescents. 2009 is the third year of this partnership that has followed a cohort of teens from 7th to 9th grade, and will continue until this cohort graduates high school. The MCH staff has been addressing adolescent health issues with this group of teens, their families and teachers.

As a Gear Up partner, youth suicide will continue to be a focus of adolescent health prevention and outreach activities.

**c. Plan for the Coming Year**
Teen Suicide will be addressed in the new school year with the Gear Up students, teachers and parents. Teen suicide will be addressed as a component of the overall adolescent health curriculum to be used in 2010. The MCH Program will also continue to partner with other community organizations to address this and other teen health issues.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |
| Annual Indicator | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 0 | 0 | 0 | 0 |
| Denominator | 1713 | 1720 | 1442 | 1291 | 1338 |
| Data Source | | | | | Vital statistics |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | Yes | Yes | Yes |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

**Notes - 2008**
AS does not have a high risk birthing facility.

**Notes - 2007**
AS does not have a facility for high risk deliveries.

**Notes - 2006**
There are no facilities specifically for high risk deliveries in American Samoa. There is only one delivery facility and it is the LBJ Tropical Medical Center.

**a. Last Year's Accomplishments**
American Samoa does not have facilities for high-risk deliveries and neonates. All high risk deliveries are handled by the American Samoa Medical Center Authority.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. This Measure does not apply to American Samoa. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
American Samoa does not have facilities for high-risk deliveries and neonates. All high risk deliveries are handled by the American Samoa Medical Center Authority.

**c. Plan for the Coming Year**
American Samoa does not have facilities for high-risk deliveries and neonates. All high risk deliveries are handled by the American Samoa Medical Center Authority.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Performance Objective | 25 | 13 | 13 | 14 | 14 |
| Annual Indicator | 12.2 | 14.7 | 15.0 | 22.1 | 19.5 |
| Numerator | 65 | 73 | 82 | 96 | 225 |
| Denominator | 531 | 496 | 547 | 435 | 1153 |
| Data Source | | | | | MCH Database |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 19 | 20 | 20 | 21 | 21 |

**Notes - 2008**
American Samoa does not use the US Standard Birth Certificate, therefore the data reported for this measure is collected manually by MCH staff from prenatal and maternity records.

**Notes - 2007**
This is preliminary data collected thus far. It is a sampling of the prenatal records. This is only provisional and will be updated in the progress report in December 2008.

**a. Last Year's Accomplishments**
Activities related to this measure include a financial incentive program implemented by the American Samoa Medical Center Authority (ASMCA). The financial package or sliding fee rewards women who access care in the first trimester, by offering a package deal that covers the costs of prenatal visits and one night in-patient post partum admission. For non-resident women, the entire prenatal, delivery and post-partum package is a flat rate of $500 for normal delivery (not including high risk or cesarean deliveries), and for residents the entire package is free provided prenatal clinic participation is consistent and starts in the first trimester.

The MCH program maintained a media campaign on radio and TV to air public service announcements promoting prenatal care and the prenatal incentive package. The incentive package is also available to women who access care at the community health centers, as long as they also meet all of the participation/eligibility criteria.

Free prenatal services are available at two Public Health clinics, in addition to the services offered at the ASMCA.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide free prenatal care at the Community Health Centers. | X | | | |
| 2. Promote the financial incentive/sliding fee prenatal program to ensure all women initiate early and continuous care. | | X | | |
| 3. Continue a multimedia campaign airing public service announcements on the benefits and importance of continuous prenatal care beginning in the first trimester. | | X | | |
| 4. Conduct an evaluation of current health communcation methods pertinent to this measure. | | | | X |
| 5. Revise healh education methods based on new information gained. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The MCH Program continues to provide free prenatal services, promotion of free services available and of the incentive package offered by the hospital for women who access care in the first trimester. The MCH Women's Health Nurse Practitioner provides free health advise and promotes Prenatal care on a weekly live broadcast radio program.

A new development towards this Performance Measure is the collocating of WIC staff to the (3) community health centers. WIC is administered under a different agency (Department of Human and Social Services) and was previously located at one central location. In 2009, coinciding with the community health center expansion from just the Tafuna Family Health Center to include the two furthest outlying clinics to the east and west of the island, the WIC agency has agreed to collocate services with the community health centers. WIC services can now be accessed at the same location as the Well Baby and Prenatal Clinics. Health assessments are part of the WIC intake process, and it is anticipated this new development will improve participation in prenatal clinics by improving accessibility of WIC services to the women who access prenatal clinics.

**c. Plan for the Coming Year**
Although efforts to improve prenatal care has shown some increase in early and continuous participation, the local rates are far below the Healthy People objective and national rates. It is apparent that new approaches must be employed to improve this measure. Better data collection and analysis is a top priority, to identify the subgroups of women who are least likely to access services in order to target strategic interventions. The effectiveness of health communications in this area must also be evaluated, to ensure the right message is reaching the right audience. Plans to do this include focus groups, and key informant interviews to evaluate current outreach and education methods. This information will be used to revise or develop new strategies in health communications, as well as to revise the health education modules used for prenatal clinics.

After the initial analysis of the PRAMS-like survey conducted in AS, it was discovered that many women who were becoming pregnant did not intend to become pregnant (at the time, or at all), nor did they access any family planning/contraceptive services. MCH plans include a closer investigation into this information, in order to address the issue of pregnancy intendedness and family support issues. MCH staff will work closely with the OBGYN and Family Planning programs at the ASMCA and women in the community to develop and implement strategies to address this issue in a culturally sensitive manner.

## D. State Performance Measures

**State Performance Measure 1:** *Percent of infants born to women receiving adequate Prenatal Care according to the Kotelchuk Index.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 10 | 11 | 12 |
| Annual Indicator | 12.2 | 14.7 | 15.0 | 22.1 | 18.2 |
| Numerator | 65 | 73 | 82 | 96 | 210 |
| Denominator | 531 | 496 | 547 | 435 | 1151 |
| Data Source | | | | | MCH data system |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 13 | 15 | 15 | 15 | 18 |

**Notes - 2008**
The data reported for this measure is collected by the MCH staff, but does not include 100% of live births. The denominator is the total number of records collected by MCH staff. As AS does not use the US Standard birth certificate, prenatal history data is not readily available but must be collected manually.

**Notes - 2007**
This data was collected from a random sample of prenatal records. Thus is provisional.

**Notes - 2006**
The data reported for this measure reflect only the total number of live birhts to women in the Tafuna district who are in the service area of the Community Health Center. This is the data available at the time of this report however it does not reflect all births for the Territory.

**a. Last Year's Accomplishments**
Activities related to this measure include a financial incentive program implemented by the American Samoa Medical Center Authority (ASMCA). The financial package or sliding fee rewards women who access care in the first trimester, by offering a package deal that covers the costs of prenatal visits and one night in-patient post partum admission. For non-resident women, the entire prenatal, delivery and post-partum package is a flat rate of $500 for normal delivery (not including high risk or cesarean deliveries), and for residents the entire package is free provided prenatal clinic participation is consistent and starts in the first trimester.

The MCH program maintained a media campaign on radio and TV to air public service announcements promoting prenatal care and the prenatal incentive package. The incentive package is also available to women who access care at the community health centers, as long as they also meet all of the participation/eligibility criteria.

Free prenatal services are available at two Public Health clinics, in addition to the services offered at the ASMCA.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide free prenatal care at the Tafuna Family Health Center, and Amouli Health Center. | | X | | |
| 2. Continue a multimedia campaign airing public service announcements on the benefits and importance of continuous prenatal care beginning in the first trimester. | | X | | |
| 3. Provide education and community awareness of the financial incentive package for early initiation of prenatal care. | | X | | |
| 4. Evaluation of health communication methods. | | | | X |
| 5. Revise health communication methods following evaluation. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The MCH Program continues to provide free prenatal services, promotion of free services available and of the incentive package offered by the hospital for women who access care in the first trimester.

A new development towards this Performance Measure is the collocating of WIC staff to the (3) community health centers. WIC is administered under a different agency (Department of Human and Social Services) and was previously located at one central location. In 2009, coinciding with the community health center expansion from just the Tafuna Family Health Center to include the two furthest outlying clinics to the east and west of the island, the WIC agency has agreed to collocate services with the community health centers. WIC services can now be accessed at the same location as the Well Baby and Prenatal Clinics. Health assessments are part of the WIC intake process, and it is anticipated this new development will improve participation in prenatal clinics by improving accessibility of WIC services to the women who access prenatal clinics.

**c. Plan for the Coming Year**
Although efforts to improve prenatal care have shown some increase in early participation, the local rates are far below the Healthy People objective and national rates. It is apparent that new approaches must be employed to improve this measure. Better data collection and analysis is a top priority, to identify the subgroups of women who are least likely to access services in order to target specific interventions. The effectiveness of health communications in this area must also be evaluated, to ensure the right message is reaching the right audience. Plans to do this include focus groups, and key informant interviews to assess how current outreach and education methods. This information will be used to revise or develop new strategies in health communications, as well as to revise the health education modules used for prenatal clinics.

After the initial analysis of the PRAMS-like survey conducted in AS, it was discovered that many women who were becoming pregnant did not intend to become pregnant (at the time or at all), nor did they access any family planning service. MCH plans include a closer investigation into this information, in order to address the issue of pregnancy intendedness and family support issues. MCH staff will work closely with the OBGYN and Family Planning programs at the ASMCA and women in the community to develop and implement strategies to address this issue in a culturally sensitive manner.

**State Performance Measure 2:** *Percentage of annual re-evaluation of Children with Special Health Care Needs (CSHCN) by the Interdisciplinary Team.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 98 | 50 | 60 |
| Annual Indicator | 47.6 | 97.9 | 76.4 | 87.9 | 91.9 |
| Numerator | 70 | 143 | 107 | 123 | 125 |
| Denominator | 147 | 146 | 140 | 140 | 136 |
| Data Source | | | | | CSHCN data |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 90 | 91 | 92 | 93 | 95 |

**a. Last Year's Accomplishments**
The data reported for this measure includes children registered with the CSHCN program and Special Education children who have received services from the MCH staff. Some of these students include those who are IEP students, but are not necessarily children with special health needs.

The CSHCN team has been able to provide home-visitations to 63% of its clientele. Due to lack of personnel and shared staff with other health clinics, providing coordinated medical, ongoing and comprehensive care within the home has been limited to the above percentage.

About 30% were SPED students seen annually for physical assessments within the classroom or at the CSHCN examine room. Consent forms were signed before a client was given a thorough assessment by the MCH Pediatrician and nurse. Further health care needs were discussed with parents who were present for this purpose or with an attending SPED teacher in the absence of the caregiver/parent.

In 2008, one of the two remaining CSHCN staff left the island to pursue continuing education. The Occupational Therapy Aide has enrolled in an Occupational Therapy program that will eventuate in becoming a registered Occupational Therapist and returning to work in American

Samoa for the CSHCN Program.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Provide evaluations for children with special health care needs in the home setting to maximize interaction with the family. | X | | | |
| 2. Continue to provide annual evaluations for children attending Special Education at the center and the other outlying schools. | X | | | |
| 3. Continue to attend grand rounds at the Pediatric Ward of the ASMCA to identify children early and ensure services are provided according to their needs. | X | | | |
| 4. Continue to partner with other agencies and service providers to coordinate services for children and their families | | | | X |
| 5. Continue to work with community health centers to track and follow-up children with special health care needs and to ensure all children receive age appropriate immunizations in a timely manner. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The CSHCN staff continues to partner with families and service agencies to ensure comprehensive and timely delivery of necessary services for CSHCN. The activities to address this measure are centered on collaborative methods to reach children where they are. This will include the CSHCN team joining the MCH Dental Outreach team in their visits to the schools so that CSHCN receive both dental and medical services in a manner that is less disruptive than physically coming to the Public Health clinics/offices.

The CSHCN team collaborates services with Helping Hands Early Intervention program for children with special health care needs from birth to 3 years, the pediatric team at LBJ Medical Center and the non-profit organization CFIDD to coordinate necessary, appropriate, and continuous medical care in the home as needed. Parents are informed of procedures, proper care and handling of child in the home. Caregivers are also given the opportunity to ask questions or share concerns regarding the care of child.

**c. Plan for the Coming Year**

One of the most significant needs of the program is for a Nurse/Case manager. The program will continue to recruit applicants for this position in 2010. This task has been made difficult by the overall shortage of nurses in the Territory as well as the government classification system whereby Department of Health staff earn less than those who work at the hospital. Payment above the minimum will be requested for this position in an effort to fill the vacancy.

Efforts are currently being made to recruit off island for Samoan nurses who are willing to move home and work. The MCH Coordinator is working closely with the Department of Human Resources to fill this position. Efforts will also be made through the Interagency Leadership Council to recruit for and fill this position.

**State Performance Measure 3:** *Percent of 2, 3, and 4 year old children who are seen in the in the MCH Well Child Clinics who access dental health services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 12 | 14 | 16 |
| Annual Indicator | | 35.3 | 10.8 | 14.9 | 31.4 |
| Numerator | | 1067 | 362 | 563 | 1532 |
| Denominator | | 3020 | 3341 | 3791 | 4875 |
| Data Source | | | | | MCH Data system |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 18 | 20 | 22 | 22 | 23 |

**a. Last Year's Accomplishments**
The data for 2008 is data received from Head Start. These are 3 and 4 year old children that are also seen at the MCH Well Child Clinics who receive dental health services at the Head Start dental clinic. The MCH school outreach team partners with the SCHIP dentist to provides Head start clients dental health care, both preventive and curative. Because it is mandatory for Head Start children to receive dental screenings and treatments, 100% of these children access their dental health services at Head Start.

There were difficulties implementing this measure at the Well Baby Clinics. Although the MCH providers can refer children to the dental clinic at the same dispensary/health center, there is only one dentist at the largest health center (Tafuna Health Center) and he is unable to handle both acute care patients and well clients. The dental clinics at the other health centers are staffed by ASMCA dentists who charge a fee for all patient visits, which is a barrier for most patients. Despite referrals to the dental clinics, most Well Baby clients either cannot be seen by the dentist, or prefer not to pay a fee for a dental visit unless there is an acute problem.

The MCH dental team was able to provide dental preventive services to 57 children in this age-group during February 2008, promoting Children's Dental Health. The team took one day each week and stationed their dental chair at each Well Child Clinic, providing dental screening, fluoride varnish application, toothbrushing demonstration, as well as giving out toothbrushes, toothpastes and floss.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Work with the dental staff at the community health centers to develop referral system for Well Baby clinics. | | | | X |
| 2. Provide protocols and supplies for all Well Baby/Child clinicians for application of flouride varnish. | X | | | |
| 3. Establish a mechanism to collect data on all referrals and 2 - 4 children seen. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

| | | | | |
|---|---|---|---|---|
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
In 2009 the MCH program in conjunction with the Tafuna Family Health Center co-sponsored a dental assistant training program. All of the MCH and SCHIP dental staff participated in this training, to train the dental assistants as well as update the dentists with current techniques, procedures and recommendations in children's' preventive dental care. This training helped increase the capacity for local dental staff to be trained in Public Health dentistry, which had not happened prior to this training.

Currently one of the MCH Well Baby providers are providing fluoride varnish as part of the routine visits. Other activities have been suspended due to lack of MCH dental staff, until the remaining MCH dentist returns from Maternity leave and the vacant dental positions are filled.

**c. Plan for the Coming Year**
The MCH dental team will work closely with the dental clinics at each of the community health centers to establish a better referral system for MCH well child visits. As one of the MCH dentists is now working at the busiest health center, efforts will be made to work closely with him to develop a referral system for both the Well Baby Clinics and the school outreach team. Similar efforts will be made with the other health centers as soon as they open the dental clinics there.

**State Performance Measure 4:** *Percentage of 4 month olds in Well Baby Clinics who are exclusively breastfed.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 25 | 25 | 30 |
| Annual Indicator | | 31.2 | 27.1 | 31.2 | 54.6 |
| Numerator | | 516 | 416 | 353 | 605 |
| Denominator | | 1652 | 1534 | 1132 | 1109 |
| Data Source | | | | | MCH data system |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 31 | 31 | 32 | 32 | 33 |

**a. Last Year's Accomplishments**
In FY 2OO8, the MCH Program continued efforts in order to lay a solid foundation of education and information on breastfeeding during the prenatal period in order to help mothers choose exclusive breastfeeding as a feeding method. The MCH Program continued to make breastfeeding a priority area in its health education efforts at the community level as well.

The MCH Staff incorporated breastfeeding education within 24 hours after delivery. The rooming-in policy allows new mothers to have full access to their newborns, and breastfeeding counseling is provided on the first day of the postpartum stay in the hospital. Free breast pumps are also available at WIC, and for mothers with premature or sick babies at the nursery to utilize in expressing breast milk for their infant.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Provide health education on breastfeeding to women attending prenatal clinics in the community health centers and the American Samoa Medical Center Authority OBGYN clinic. | | X | | |
| 2. Continue to air public service announcements on the benefits of breastfeeding | | X | | |
| 3. Continue to provide breastfeeding coaching and counseling to postpartum mothers at the Maternity Ward at American Samoa Medical Center Authority. | | X | | |
| 4. Develop a breastfeeding plan to be used as a guide for mothers to prepare for breastfeeding during the prenatal period. | | | | X |
| 5. Recruit breastfeeding mentors from the community to provide support after hospital discharge. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The MCH staff continue breastfeeding education and counseling to women accessing prenatal care in all of the community health centers as well as the OBGYN clinic. One on one counseling is also conducted at the Maternity Ward post delivery. The MCH staff are on hand to provide support and coaching for mothers who need help with breastfeeding initiation. The MCH hotline telephone number is also given out for mothers to call if they need additional support at home. Breastfeeding is one of the nutritional topics covered in education and counseling at the well baby clinics for mothers who are bringing in their infants or toddlers in for a Well Baby Clinic visit.

Breastfeeding radio spots air continuously on the local radio stations throughout the year. The MCH staff also broadcast television shows on breastfeeding.

**c. Plan for the Coming Year**

The MCH staff plan to conduct focus groups, and some informal information gathering discussions with women in their last trimester or within 6 months of delivery in order to ascertain their knowledge and practices around breastfeeding. Although breastfeeding is continuously promoted through education and mass media, the secondary audiences for this information have not been identified. Most of the information has been traditionally focused on the mothers, however those who are involved in the decision making process need to be included as well. With this information, the approaches and activities used to promote breastfeeding can be fine tuned and more focused.

The MCH staff plan to develop or adopt a framework breastfeeding plan for prenatal and post-partum mothers to be used as a guide to help reinforce their plans for breastfeeding. Similar to a birthing plan, the idea is to help women prepare for breastfeeding prior to delivery to ensure greater success. The plan will include helpful tips and educational material, from positioning and nipple care to including fathers and other family members in the feeding plan. Often mothers are not prepared for the demands and challenges of breastfeeding and often are not able to overcome barriers. The breastfeeding plan will help women anticipate challenges and decide with her partner and family how to address those challenges, with guidance and assistance provided by MCH staff both prenatally and postpartum. The guide will also contain contact

information and resources where they can find help.

Finally, the MCH Program plans to develop a breastfeeding support network of women in the community, church groups who are interested and willing to be breastfeeding mentors in their communities. One of the barriers to breastfeeding women have identified is the lack of support at home. To address this need the MCH program plans to develop partnerships with women in the community who can provide breastfeeding support in the homes. The MCH staff will provide training, coordination, and technical support and follow up for the mentors. This will be a pilot project in 2010,

**State Performance Measure 5:** *Percent of 14-17 year olds attending school who admitted to smoking in the last 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 40 | 39 | 24 |
| Annual Indicator | | 0.0 | 40.0 | 24.2 | 24.2 |
| Numerator | | 0 | 614 | 878 | 878 |
| Denominator | | 1535 | 1535 | 3625 | 3625 |
| Data Source | | | | | YRBS data |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 24 | 22 | 22 | 20 | 20 |

**Notes - 2007**
The numerator reported for this measure is the total number of survey participants in the 2007 YRBS, which had greater success in response rate than in previous years.

**Notes - 2006**
This data reflects the last YRBS data that was available for 1999. The most current YRBS data has yet to be released by the Department of Education and CDC.

**a. Last Year's Accomplishments**
The data for this performance measure is derived from the YRBS data from the Department of Education for 2007. The data for the 2009 YRBS have not yet been released.

The MCH program works closely with the Health Curriculum section of the Department of Education, Gear Up, the Comprehensive Cancer Control Program, and Taitaitama Project (substance abuse prevention) to coordinate outreach activities for teens. These activities center on teen risk behaviors such as obesity and tobacco use.

The Department of Health is currently working to re-introduce a Clean Air bill into the local legislature to prevent environmental tobacco smoke. The local task force on selling tobacco to minors has also been active in enforcing the tobacco selling laws at local stores and vendors. Currently, new public service announcements on tobacco use among youth are being developed and piloted with teens from the local community and should be launched later in 2009.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue to work with GearUp students to address adolescent risk behaviors. | | X | | |

| | | | | |
|---|---|---|---|---|
| 2. A Clean Air bill will be introduced to the legislature to prevent exposure to second hand smoke. | | | | X |
| 3. TATU training – teen mentoring against tobacco use training of trainers planned for 2010. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The MCH staff work in collaboration with the Gear Up program to address adolescent health issues with students, teachers and parents. Another partner in this collaboration is the substance abuse prevention coalition. A key focus of this partnership is to ensure academic success of students by offering health and social supports such as skills to avoid risk behaviors. MCH will continue to work with Gear Up to address adolescent health issues such as tobacco use.

**c. Plan for the Coming Year**
The MCH Program will continue to partner with the Comprehensive Cancer Control Program and Community Cancer Coalition, and the Substance Abuse Prevention project to implement TATU -- Teens Against Tobacco Use. This model is a teen mentoring program aimed at using teens as facilitators in tobacco use prevention classes. It is anticipated that a training of trainers can be organized for the later part of 2009, where teens will be invited to participate. Trainers will be recruited from the Gear Up students, the substance abuse prevention community coalitions and the community to participate in this project.

**State Performance Measure 6:** *To decrease the percentage of 1 year olds with low hemoglobin (less than 11)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 54 | 29 | 29 |
| Annual Indicator | | 30.0 | 31.0 | 10.9 | 27.2 |
| Numerator | | 517 | 484 | 157 | 339 |
| Denominator | | 1726 | 1562 | 1440 | 1245 |
| Data Source | | | | | MCH data system |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 28 | 28 | 27 | 27 | 26 |

**Notes - 2007**
In 2007 there was equipment failure with the hemoglobin testing units. For this reason the data reported for this year reflects a much smaller number of children screened. The program has since ordered new machines and this data is expected to be a better reflection of hemoglobin testing in 2009.

**a. Last Year's Accomplishments**

The MCH Program is currently reporting this data from the Well Baby Clinics, of those children who participate in WIC. MCH staff provide individual nutrition counseling with the parents or caregivers at the Well Baby Clinics. These sessions includes:

- Breastfeeding benefits (for mother and infant)
- Infant feeding: > Infant food preparation for children 6mos to 1 year old.
- Young child feeding: > Healthy local diets for children 1 year old to 5years old.
- 24 hour diet recall

The MCH Staff utilizes the "SOAP (subjective objective assessment planning)" method in the client's folders to ensure follow-up in clients care. This method basically covers the development of a care plan specifically for nutrition, that is done collaboratively with parents/care givers. The plan is documented and can be followed up by any of the Well Baby Clinic staff in order to track each child's progress.

In addition, group teachings are done in all Well Baby Clinics. The total number of children who received nutrition education at the Well Baby Clinics in 2008 was 1477.

In FY 2008, the MCH Program celebrated National Nutrition Month. For this month the MCH Program had a number of promotional activities to promote children's nutrition. The MCH Program organized a poster and recipe competition for elementary schools. Both government and private schools participated. The event was advertised on the TV, newspaper and radio. As a result, 116 children participated during these activities.

Radio spots continued to air on promotion of infant and young child feeding with a number to call if there are any questions. TV programs continue to air discussing the importance of nutrition.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue to provide nutrition education and awareness to families at Well Baby/Child clinics. | | X | | |
| 2. Provide hemoglobin screening for infants and 1 year olds at the Well Baby Clinic along with nutrition education. | X | | | |
| 3. Provide iron supplements to families with children who have low hemoglobin levels free of charge. | X | | | |
| 4. Provide multivitamin supplements to children free of charge with nutrition counseling and education. | X | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The MCH Program offers nutrition education and counseling for children at the well baby clinics, at the day cares and through public service announcements. Posters and pamphlets have been distributed and posted to all health centers and other public places to increase awareness about healthy nutrition. These materials have been adapted to feature local foods, both good and bad and have also been translated. The nutritional value of local fruits and vegetables has been incorporated into health education sessions for children and families.

A new development towards this Performance Measure is the collocating of WIC staff to the (3) community health centers. WIC is administered under a different agency (Department of Human

and Social Services) and was previously located at one central location. In 2009, coinciding with the community health center expansion from just the Tafuna Family Health Center to include the two furthest outlying clinics to the east and west of the island, the WIC agency has agreed to collocate services with the community health centers. WIC services can now be accessed at the same location as the Well Baby and Prenatal Clinics. Health assessments are part of the WIC intake process, and it is anticipated this new development will strengthen capacity to address this measure by coordinating nutrition education efforts as well as increasing accessibility of Well Baby Clinic services to the WIC clients.

**c. Plan for the Coming Year**

As education and public awareness are the larger parts of this performance measure, the MCH program plans to conduct an assessment of the methods of education and communication used for childhood nutrition. This is to find out what families are learning from the current communication methods, confirm which methods are most effective for our population and also to find out who primary and secondary audiences for this information really is. Those who are responsible for feeding and meal preparation for the children need to be targeted, and they may not be the parents or those who are currently being targeted.

Continuing education on child BMI, growth and development is a continuing need for MCH and for nursing staff as well. Training and continuing education will be provided on these topics in 2010, to strengthen skills and competencies among service providers for children. This will begin with Public Health staff first, and hopefully expanded to other service providers such as day cares. A third activity will be to review and revise the Well Baby Clinic education modules to address this issue, and staff in-service on the correct usage of the modules.

Recommendations for nutrition intervention in this age group include iron supplementation, deworming, exclusive breastfeeding, and use of fortified foods. In the past the MCH program has made efforts to provide iron supplements for children served at Well Baby Clinics with iron deficiency, however there is an expensive practice and cannot be sustained with current resources. Supplementation will be continued in 2010 but only a limited supply can be furnished for those families in greatest need. Other families will be have to purchase the iron supplements. Fortified foods are readily available, and are included in the WIC food package which a majority of children have access to. Deworming is being implemented as part of the lymphatic filariasis elimination campaign, however the medication is not recommended for children below 2 years of age. Deworming will have to be prescribed by a clinician. Breastfeeding has been a MCH priority for the last 10 years, and will continue to be in 2010.

**State Performance Measure 7:** *Percent of children among the children with special needs who are known to the CSN Program who receive an annual dental assessment.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 60 | 62 |
| Annual Indicator | | 20.5 | 57.9 | 87.9 | 93.4 |
| Numerator | | 30 | 81 | 123 | 127 |
| Denominator | | 146 | 140 | 140 | 136 |
| Data Source | | | | | MCH School Outreach data |
| Is the Data Provisional or Final? | | | | Final | Final |

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|
| Annual Performance Objective | 64 | 66 | 68 | 68 | 69 |

**a. Last Year's Accomplishments**
Children with Special Health Care Needs (CSHCN) received better dental access last year compared to previous years. The annual performance measure targeted for year 2008 was 90%. The actual data shown in the table above is provisional and not yet finalized. This number include all kids seen at Elementary schools that were in the Special Education Program (SPED), ECE SPED, those whom were seen during home visits together with the CSN nurse practitioner, as well as those whom were present at the Matafao SPED office during a three day dental screening in the month of October (2007) to promote Disability Month. All children were referred to the nearest dental clinic (dental home) for further dental treatment if needed. Every child seen gets a fluoride varnish application, given a toothbrush and toothpaste, with oral hygiene instructions reinforced using tooth-brushing demonstrations with models and puppets to both the child and parents/caregivers if present.

During the disability month on October 2007, the dental team provided dental screening, oral hygiene reinforcements, plus dental referrals (to the nearest dental clinic for treatments if needed) for children with Special Health Care Needs. This was a partnership between the MCH programs and the CFIDD, Center for Families of Individuals with Developmental Disabilities.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The CSHCN and dental team will partner to ensure children with special health care needs who are attending school are seen by the school dental team. | | | | |
| 2. The CSHCN and dental teams will provide dental assessments to children with special health care needs in the homes. | | | | |
| 3. Children with special health care needs will be seen in the community health center nearest to them for dental treatments. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
CSN students are continued to be seen in school settings (Elementary), during home visits and at the CSN office (Samoana High School). Children receive both a physical and dental screening. During dental screenings, they are given fluoride varnish application, toothbrushing demo to both children and caregivers, and a report card that informs caregivers the dental status of their child and to see a dentist at the nearest dental clinic if dental treatments are needed.

**c. Plan for the Coming Year**
Since the past year's success rate of the CSN population seen by the dental team was due to the consistent coverage of CSN children in the elementary schools, this will continue in the new

school year. Schedules will be consistently reviewed so that the CSN nurse practitioner, Mrs. Tele Hill, will be able available to provide physical screenings as well.

## E. Health Status Indicators

**Introduction**

Annual reporting on the Health Status Indicators has enabled the MCH Program and the Department of Health to evaluate its current data collection and reporting systems. The systems currently in place are not adequately or accurately meeting the data needs of the Department of Health. Without current and accurate data the Department cannot fulfill its role of monitoring and surveillance. This has been an unmet need for many years. However, the MCH/SSDI Programs are taking a leadership role in building a partnership between the American Samoa Medical Center Authority (ASMCA) and the Department of Health to meet the health information needs of the community as a collaborative effort.

***/2010/***
***The shared access to the ASMCA electronic health record (EHR) has established a data linkage that has not been possible before. Although the primary use of the is patient management, it is anticipated that with further software development it will enable health data to be analysed for surveillance, monitoring and informed planning purposes. Access to the EHR will soon be available from all Public Health clinic sites, making it a universal health record for the Territory.***
***//2010//***

**Health Status Indicators 01A:** *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 3.3 | 3.8 | 2.8 | 3.3 | 1.6 |
| Numerator | 57 | 65 | 41 | 42 | 21 |
| Denominator | 1713 | 1720 | 1442 | 1291 | 1338 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**

Low birth weight prevention measures include all efforts to:

1. Provide free prenatal care at community based health centers
2. Encourage women to participate in prenatal care services early and continuously
3. Improve the nutritional status of women and expecting mothers
4. Promote overall wellness in women and their families to support healthy pregnancies, appropriate inter-pregnancy gaps, use of family planning, and positive birth outcomes.

MCH continues to offer free prenatal clinics services, assisting women enroll in the financial incentive program at ASMCA to help alleviate hospital charges, mass media campaigns and

health education on healthy pregnancies.

Expansion and collocation of WIC services at the community health centers is also a positive step. It is anticipated enrolling/participating in WIC will serve as an incentive or motivation for women to come early and keep all appointments.

**Health Status Indicators 01B:** *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 3.0 | 3.0 | 2.6 | 3.0 | 1.5 |
| Numerator | 50 | 51 | 37 | 38 | 20 |
| Denominator | 1681 | 1689 | 1424 | 1271 | 1320 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
Low birth weight prevention measures include all efforts to:
1. Provide free prenatal care at community based health centers
2. Encourage women to participate in prenatal care services early and continuously
3. Improve the nutritional status of women and expecting mothers
4. Promote overall wellness in women and their families to support healthy pregnancies, appropriate inter-pregnancy gaps, use of family planning, and positive birth outcomes.

MCH continues to offer free prenatal clinics services, assisting women enroll in the financial incentive program at ASMCA to help alleviate hospital charges, mass media campaigns and health education on healthy pregnancies.

Expansion and collocation of WIC services at the community health centers is also a positive step. It is anticipated enrolling/participating in WIC will serve as an incentive or motivation for women to come early and keep all appointments.

**Health Status Indicators 02A:** *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 0.2 | 0.3 | 0.6 | 0.5 | 0.4 |
| Numerator | 4 | 5 | 8 | 7 | 6 |
| Denominator | 1713 | 1720 | 1442 | 1291 | 1338 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
Very low birth weight is uncommon in American Samoa. Over the past 5010 years the total number of low birht weigt live birth has remained under 10.

Low birth weight prevention measures include all efforts to:
1. Provide free prenatal care at community based health centers
2. Encourage women to participate in prenatal care services early and continuously
3. Improve the nutritional status of women and expecting mothers
4. Promote overall wellness in women and their families to support healthy pregnancies, appropriate inter-pregnancy gaps, use of family planning, and positive birth outcomes.

MCH continues to offer free prenatal clinics services, assisting women enroll in the financial incentive program at ASMCA to help alleviate hospital charges, mass media campaigns and health education on healthy pregnancies.

Expansion and collocation of WIC services at the community health centers is also a positive step. It is anticipated enrolling/participating in WIC will serve as an incentive or motivation for women to come early and keep all appointments.

**Health Status Indicators 02B:** *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 0.2 | 0.3 | 0.6 | 0.6 | 0.5 |
| Numerator | 3 | 5 | 8 | 7 | 6 |
| Denominator | 1681 | 1689 | 1424 | 1271 | 1320 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
Low birth weight prevention measures include all efforts to:
1. Provide free prenatal care at community based health centers
2. Encourage women to participate in prenatal care services early and continuously
3. Improve the nutritional status of women and expecting mothers
4. Promote overall wellness in women and their families to support healthy pregnancies, appropriate inter-pregnancy gaps, use of family planning, and positive birth outcomes.

MCH continues to offer free prenatal clinics services, assisting women enroll in the financial incentive program at ASMCA to help alleviate hospital charges, mass media campaigns and health education on healthy pregnancies.

Expansion and collocation of WIC services at the community health centers is also a positive step. It is anticipated enrolling/participating in WIC will serve as an incentive or motivation for women to come early and keep all appointments.

**Health Status Indicators 03A:** *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 4.0 | 4.0 | 4.4 | 3.8 | 3.9 |
| Numerator | 1 | 1 | 1 | 1 | 1 |
| Denominator | 24852 | 24852 | 22720 | 26444 | 25783 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
MCH will continue to promote child safety in Well Baby and Prenatal clinics, school and community outreach activities as well as with the "Gear Up" program.

**Health Status Indicators 03B:** *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 4.0 | 0.0 | 4.4 | 3.8 | 0.0 |
| Numerator | 1 | 0 | 1 | 1 | 0 |
| Denominator | 24852 | 24852 | 22720 | 26444 | 25783 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
The MCH staff will partner with the Office of Highway Safety and the EMSC program to promote child safety and vehicular safety in the community. In a partnership with the Office of Highway safety, the MCH Program will be expanding data collection activities to the community health centers and village dispensaries as well as increase public awareness on child vehicle safety through media/public service announcements.

**Health Status Indicators 03C:** *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 18.9 | 28.4 | 27.6 | 0.0 | 8.5 |
| Numerator | 2 | 3 | 3 | 0 | 1 |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | 10579 | 10579 | 10870 | 11546 | 11772 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
There was only one reported motor vehicle deaths reported in 2008. This performance measure is impacted by the very low speed limit of 25 miles per hour in the Territory, as well as enforcement of the limits. The Territory has seen an increase in the number of vehicles on the road and speeding has been hindered with added congestion on the roadways. Enforcement of seat belts, speeding and drinking and driving laws have also helped prevent motor vehicular accidents.

**Health Status Indicators 04A:** *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 0.0 | 58.4 | 94.5 | 77.6 |
| Numerator | 0 | 0 | 13 | 25 | 20 |
| Denominator | 23500 | 23179 | 22270 | 26444 | 25783 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
Injury prevention is one of the adolescent heath topics to be covered next year through Gear Up as well and in the Well Baby and Prenatal clinics, and community outreach activities. The MCH program is parntering with the Office of Vital Statistics, EMSC and the Office of Highway safety to plan and implement injury prevention activities in 2010.

**Health Status Indicators 04B:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 62.0 | 53.7 | 39.6 | 41.6 | 38.8 |
| Numerator | 15 | 11 | 9 | 11 | 10 |
| Denominator | 24189 | 20486 | 22720 | 26444 | 25783 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
MCH will continue to promote vehicular safety through education at the community health centers, the day care centers and through the media. The MCH Program is also partnering with the Office of Highway Safety to strengthen data capacity for this measure, focusing on reporting measures in place for highway accidents that will shape intervention efforts.

**Health Status Indicators 04C:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 31.3 | 51.6 | 36.8 | 129.9 | 101.9 |
| Numerator | 3 | 5 | 4 | 15 | 12 |
| Denominator | 9589 | 9699 | 10870 | 11546 | 11772 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
There were no reported motor vehicle deaths reported in 2008. This performance measure is impacted by the very low speed limit of 25 miles per hour in the Territory, as well as enforcement of the limits. The Territory has seen an increase in the number of vehicles on the road and speeding has been hindered with added congestion on the roadways.

**Health Status Indicators 05A:** *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 0.2 | 11.7 | 10.2 | 10.7 |
| Numerator | 0 | 1 | 35 | 30 | 32 |
| Denominator | 4723 | 5611 | 2990 | 2946 | 2994 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**

The MCH physician also provides STD screening when there are referrals from the hospital, as well as a routine part of prenatal services. Although there is awareness about STD's in American Samoa, youth tend to have a very low perceived risk of infections. There is also a barrier in the availabilty of free condoms, most condoms are available but not everyone can afford to buy them.

**Health Status Indicators 05B:** *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 0.1 | 4.1 | 4.4 | 7.0 |
| Numerator | 0 | 1 | 46 | 54 | 86 |
| Denominator | 11324 | 11659 | 11260 | 12138 | 12348 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Narrative:**
Although there is awareness about STD's in the community, by and large people do not use barrier contraceptive methods or any methods. This is a very sensitive issue and it is hard to discuss, especially among adults as they get older. It is still perceived as a taboo topic. The perceived risk for STD's is very low in the local community making it even more challenging to address the issue.

**Health Status Indicators 06A:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

| **CATEGORY**<br>TOTAL POPULATION BY RACE | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Infants 0 to 1 | 2087 | 0 | 0 | 0 | 0 | 2087 | 0 | 0 |
| Children 1 through 4 | 7370 | 0 | 0 | 0 | 0 | 7370 | 0 | 0 |
| Children 5 through 9 | 9419 | 0 | 0 | 0 | 0 | 9419 | 0 | 0 |
| Children 10 through 14 | 7987 | 0 | 0 | 0 | 0 | 7987 | 0 | 0 |
| Children 15 through 19 | 6317 | 0 | 0 | 0 | 0 | 6317 | 0 | 0 |
| Children 20 through 24 | 5413 | 0 | 0 | 0 | 0 | 5413 | 0 | 0 |
| Children 0 through 24 | 38593 | 0 | 0 | 0 | 0 | 38593 | 0 | 0 |

**Notes - 2010**

Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

**Narrative:**
Data for age by race is currently not available for this indicator. The numbers reported are mid-census estimates however the Territory is upwards of 80% Samoan, with only a few variations which include other Pacific islanders and asians.

**Health Status Indicators 06B:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

| **CATEGORY**<br>TOTAL POPULATION BY HISPANIC ETHNICITY | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Infants 0 to 1 | 2087 | 0 | 0 |
| Children 1 through 4 | 7370 | 0 | 0 |
| Children 5 through 9 | 9419 | 0 | 0 |
| Children 10 through 14 | 7987 | 0 | 0 |
| Children 15 through 19 | 6317 | 0 | 0 |
| Children 20 through 24 | 5413 | 0 | 0 |
| Children 0 through 24 | 38593 | 0 | 0 |

**Notes - 2010**
Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

**Narrative:**
Data for age by race is currently not available for this indicator. The numbers reported are mid-census estimates however the Territory is upwards of 80% Samoan, with only a few variations which include other Pacific islanders and asians.

**Health Status Indicators 07A:** *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

| **CATEGORY** Total live births | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Women < 15 | 13009 | 0 | 0 | 0 | 0 | 13009 | 0 | 0 |
| Women 15 through 17 | 1856 | 0 | 0 | 0 | 0 | 1856 | 0 | 0 |
| Women 18 through 19 | 1138 | 0 | 0 | 0 | 0 | 1138 | 0 | 0 |
| Women 20 through 34 | 7825 | 0 | 0 | 0 | 0 | 7825 | 0 | 0 |
| Women 35 or older | 10067 | 0 | 0 | 0 | 0 | 10067 | 0 | 0 |
| Women of all ages | 33895 | 0 | 0 | 0 | 0 | 33895 | 0 | 0 |

**Notes - 2010**

**Narrative:**
Data for age by race is currently not available for this indicator. The numbers reported are mid-census estimates however the Territory is upwards of 80% Samoan, with only a few variations which include other Pacific islanders and asians.

**Health Status Indicators 07B:** *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

| **CATEGORY** Total live births | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Women < 15 | 13009 | 0 | 0 |
| Women 15 through 17 | 1856 | 0 | 0 |
| Women 18 through 19 | 1138 | 0 | 0 |
| Women 20 through 34 | 7825 | 0 | 0 |
| Women 35 or older | 10067 | 0 | 0 |
| Women of all ages | 33895 | 0 | 0 |

**Notes - 2010**

**Narrative:**
Data for age by race is currently not available for this indicator. The numbers reported are mid-census estimates however the Territory is upwards of 80% Samoan, with only a few variations which include other Pacific islanders and asians.

**Health Status Indicators 08A:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

| **CATEGORY** Total deaths | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Infants 0 to 1 | 1345 | 0 | 0 | 0 | 0 | 1345 | 0 | 0 |
| Children 1 through 4 | 7370 | 0 | 0 | 0 | 0 | 7370 | 0 | 0 |
| Children 5 through 9 | 9419 | 0 | 0 | 0 | 0 | 9419 | 0 | 0 |
| Children 10 through 14 | 7987 | 0 | 0 | 0 | 0 | 7987 | 0 | 0 |
| Children 15 through 19 | 6317 | 0 | 0 | 0 | 0 | 6317 | 0 | 0 |
| Children 20 through 24 | 5413 | 0 | 0 | 0 | 0 | 5413 | 0 | 0 |
| Children 0 through 24 | 37851 | 0 | 0 | 0 | 0 | 37851 | 0 | 0 |

**Notes - 2010**
Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

**Narrative:**
Data for age by race is currently not available for this indicator. The numbers reported are mid-census estimates however the Territory is upwards of 80% Samoan, with only a few variations which include other Pacific islanders and asians.

**Health Status Indicators 08B:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

| **CATEGORY** Total deaths | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Infants 0 to 1 | 1345 | 0 | 0 |
| Children 1 through 4 | 7370 | 0 | 0 |
| Children 5 through 9 | 9419 | 0 | 0 |
| Children 10 through 14 | 7987 | 0 | 0 |
| Children 15 through | 6317 | 0 | 0 |

| | | | |
|---|---|---|---|
| 19 | | | |
| Children 20 through 24 | 5413 | 0 | 0 |
| Children 0 through 24 | 37851 | 0 | 0 |

**Notes - 2010**
Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

**Narrative:**
Data for age by race is currently not available for this indicator. The numbers reported are mid-census estimates however the Territory is upwards of 80% Samoan, with only a few variations which include other Pacific islanders and asians.

**Health Status Indicators 09A:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

| **CATEGORY** Misc Data BY RACE | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** | **Specific Reporting Year** |
|---|---|---|---|---|---|---|---|---|---|
| All children 0 through 19 | 13687 | 0 | 0 | 0 | 0 | 13687 | 0 | 0 | 2008 |
| Percent in household headed by single parent | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2008 |
| Percent in TANF (Grant) families | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2008 |
| Number enrolled in Medicaid | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2008 |
| Number enrolled in SCHIP | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2008 |
| Number living in foster home care | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2008 |
| Number enrolled in food stamp program | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2008 |
| Number enrolled in WIC | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2008 |
| Rate (per | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2008 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 100,000) of juvenile crime arrests | | | | | | | | | |
| Percentage of high school drop-outs (grade 9 through 12) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2008 |

**Notes - 2010**

**Narrative:**
Data for age by race is currently not available for this indicator. The numbers reported are mid-census estimates however the Territory is upwards of 80% Samoan, with only a few variations which include other Pacific islanders and asians.

**Health Status Indicators 09B:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

| **CATEGORY** Miscellaneous Data BY HISPANIC ETHNICITY | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** | **Specific Reporting Year** |
|---|---|---|---|---|
| All children 0 through 19 | 13687 | 0 | 0 | 2008 |
| Percent in household headed by single parent | 0.0 | 0.0 | 0.0 | 2008 |
| Percent in TANF (Grant) families | 0.0 | 0.0 | 0.0 | 2008 |
| Number enrolled in Medicaid | 0 | 0 | 0 | 2008 |
| Number enrolled in SCHIP | 0 | 0 | 0 | 2008 |
| Number living in foster home care | 0 | 0 | 0 | 2008 |
| Number enrolled in food stamp program | 0 | 0 | 0 | 2008 |
| Number enrolled in WIC | 0 | 0 | 0 | 2008 |
| Rate (per 100,000) of juvenile crime arrests | 0.0 | 0.0 | 0.0 | 2008 |
| Percentage of high school drop-outs (grade 9 through 12) | 0.0 | 0.0 | 0.0 | 2008 |

**Notes - 2010**

**Narrative:**
Data for age by race is currently not available for this indicator. The numbers reported are mid-census estimates however the Territory is upwards of 80% Samoan, with only a few variations which include other Pacific islanders and asians. No other data was available at the time of this report.

**Health Status Indicators 10:** *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

| **Geographic Living Area** | **Total** |
|---|---|
| Living in metropolitan areas | 0 |
| Living in urban areas | 1642 |
| Living in rural areas | 12045 |

| | |
|---|---|
| Living in frontier areas | 0 |
| **Total** - all children 0 through 19 | 13687 |

**Notes - 2010**
Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

**Narrative:**
As there is no big city in American Samoa so there are no metropolitan ares. This data represent mid-census estimtes.

**Health Status Indicators 11:** *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|---|---|
| Total Population | 69200.0 |
| Percent Below: 50% of poverty | 28.0 |
| 100% of poverty | 60.0 |
| 200% of poverty | 85.0 |

**Notes - 2010**
Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

**Narrative:**
Although 60% of the population is under the federal poverty level, the majority of children live within those households.

**Health Status Indicators 12:** *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|---|---|
| Children 0 through 19 years old | 13687.0 |
| Percent Below: 50% of poverty | 28.0 |
| 100% of poverty | 60.0 |
| 200% of poverty | 85.0 |

**Notes - 2010**
Data source: census estimates

Data source: census estimates

Data source: census estimates

Data source: census estimates

**Narrative:**
Although 60% of the population is under the federal poverty level, the majority of children live within those households.

## F. Other Program Activities

Filariasis Elimination Campaign: The Title V staff have and will continue to expend a noteworthy amount of time working on the Filariasis Elimination campaign. This is a joint effort with the World Health Organization and CDC that was initiated in 2001 and will continue for five years. The major thrust of the Filariasis Elimination campaign is a Mass Drug Administration (MDA). Title V staff serve in leadership roles for the Community Health Services and Nursing Division in the planning and implementation of the MDA. MCH staff continues to volunteer time after regular working hours to support this campaign. Title V staff continued to participate in this campaign in 2005 & 2006.

Title V participated in disabilities awareness week. Staff members conducted outreach and health education activities including a trip to the outer islands of Manu'a to provide screening and assessments for children there. This was done in collaboration with the early intervention program. Since the MCH pediatrician has come on staff in 2006 he has been to Manu'a twice with the MCH dentists and assessed over 300 children.

Title V staff will participate in a number of conferences and workshops held off-island:

Two MCH staff members will attend the MCH Grant Review in Honolulu.
Title V staff will be represented at the annual Partnership meeting. Travel funds previously budgeted for travel have been reallocated to allow for other inputs, more vital to Title V programming.

MCH HOTLINE
The MCH hotline number is widely publicized and members of the public are urged to call with concerns.

The MCH Coordinator is an active member of the Department of Health Data Committee which coordinates data planning activities for the Department. The MCH staff played a key role in facilitating partnerships and linkages for data sharing between the hospital and public health. In 2006 the Department of Health and the LBJ Medical Authority entered into a Memorandum of Agreement to share an electronic health record system. In May 2006 a team of information technology specialists arrived in the Territory and set up access to the electronic health record system from the Tafuna Health Center and the Communicable Diseases clinic. This has enabled clinicians at both entities to share the same electronic patient records and created a long anticipated data linkage. The MCH Staff will continue to work on this project with members of the LBJ Medical Authority and the Data Committee.

***/2010/***
***The MCH Program has strengthened and developed partnerships with several agencies to include Department of Education, office of Highway Safety, and the newly established Population Pressure Commission. Activities coordinated with the Department of Education include a Wellness Fair, which was a multi-agency collaboration to offer health promotion activities to the community. The Fair was a success, with over 300 people participating in interactive learning activities for all ages. The main audience for the fair was families with children, from early childhood to college age.***

***In a partnership with the Office of Highway safety, the MCH Program will be expanding data collection activities to the community health centers and village dispensaries as well as increase public awareness on child vehicle safety through media/public service announcements.***

***The MCH Program will also be partnering with the Office of Highway safety to implement a child restraint promotion program. The Office of Highway safety will provide technical assistance to MCH staff in order to provide education to parents on appropriate use of car/booster seats. Through this partnership, families will be able to attain car seats for no cost while ensuring parents participate in a vehicular safety education program. It is anticipated this project will be incorporated into routine prenatal and well baby/child clinic services.***

***A new partner this year, is the Department of Commerce and the Governor's Population Pressure Commission. The commission is tasked with developing a strategic action plan to address population growth in the Territory. The commission consists of five agencies: Commerce, Health, Education, Immigration, and Youth and Women's Affairs. Each agency has representatives to a work group that reports to the commission. The MCH Coordinator and Family Nurse Practitioner serve on this work group. The work group is currently focusing on developing/adopting health curriculum (to include reproductive health) for the schools, development of a Territorial Health Plan, and addressing the need for contraceptive and family planning services. These activities will continue in 2010.***

***The MCH Coordinator is also involved in the work group on Health Information Technology, the Community Cancer Coalition Nutrition work group, and the health advisory group for Early Childhood Education. MCH program staff are also involved in H1N1 outreach activities, and the lymphatic filariasis elimination campaign. //2010//***.

## G. Technical Assistance

As the MCH Needs Assessment is due in 2010, the highest priority for technical assistance is centered around Needs Assessment. The MCH program has contracted Dr. Henry Ichiho to provide technical assistance for the Needs Assessment process. Dr. Ichiho will be on site to provide the following technical assistance for the MCH staff, partners, and stakeholders:

Visit #1
1. Provide technical assistance training on the concepts and basic principles of conducting a needs assessment for maternal and child health services. This will include a curriculum and PowerPoint presentations with hard copy handouts
2. Develop a list of potential partners and stakeholders to participate with the MCH Program in conducting the data collection, analysis of data, and setting priorities.
3. Develop the procedures for data collection including a list of data indicators and data definitions for data collection.
4. Identifying data collecting tasks that will need to accomplished by the MCH staff, partners, and stakeholders before Visit #2
5. Submit a final report of the accomplishments of the consultation visit

Visit #2
1. Provide technical assistance training on the concepts and basic principles of epidemiologic analysis of the data collected. This will include a curriculum and PowerPoint presentations with hard copy handouts.
2. Conduct data analysis on selected data sets that includes the use of census data and calculating proportions and rates
3. Develop trend analysis of selected MCH indicators using the Year 2000, Year 2005, and current data.
4. Develop the plans for sharing the data analysis with community partners and stakeholders
5. Submit a final report of the accomplishments of the consultation visit

MCH has contracted Dr. Ichiho for the current fiscal year, and funding for technical assistance has been included in the MCH 2010 budget, however with a decrease in MCH funding additional assistance is requested for this effort.

There has been a major change in MCH staffing since the last needs assessment process. None of the current MCH staff have any training or experience in this area. Dr. Ichiho will provide training for these staff and other MCH partners and stakeholders who will be engaged in the Needs Assessment process during this time. This training is invaluable since it will be on site, available to more people and may be the first and only opportunity for this type of training for many people.

Also a priority of Technical Assistance continues to be in the area of Data Systems Development and Data Analysis/Interpretation. The overall results of SSDI are expected to improve data collection activities significantly. However, both MCH and SSDI Programs will continue to benefit from technical assistance in the area of Data Systems Development. This is reflected as the highest priority on Form 15.

# V. Budget Narrative

## A. Expenditures

The expenditures reported for 2008 reflect a difference in the amount originally budgeted for that fiscal year and the actual amount expended. There is a difference as the amount budgeted far exceeded the actual amount awarded for that year.

## B. Budget

MCH BUDGET FY 2009 JUSTIFICATION

| MCH | Total |
|---|---|
| PERSONNEL | |
| CSN Nurse | $25,000 |
| Community Health Assistant (Roe) | $9,431 |
| Community Health Assistant (Sauni) | $13,867 |
| Data Clerk - (Anetta) | $11,437 |
| Dental Assistant (vacant) | $8,500 |
| Dentist (Uso) | $37,492 |
| MCH Pediatrician (Fuimaono) | $42,692 |
| Family Nurse Practitioner (Hill) | $40,612 |
| MCH Nurse (LPN 3) | $14,000 |
| MCH Coordinator (Tulafono) | $33,332 |
| Health Care Provider (Sesepasara) | $40,612 |
| Health Education Manager (Utu) | $25,360 |
| Nutritionist 1 (Meleisea) | $18,271 |
| Nutritionist 2 (Leiato) | $19,669 |
| Physician | $38,000 |
| Subtotal Title V Salaries | $378,275 |
| Fringe Benefits | $61,281 |
| Total Salaries + Fringe Benefits | $378,275 |
| LOCAL MATCH | |
| Deputy Director (FTE 20%) | $8,969 |
| Nutritionist 2 (Alailefaleula) | $19,940 |
| Finance Admin. Asst. (10% FTE) | $1,317 |
| Finance Admin. Asst. (10% FTE) | $1,317 |
| Nursing Supervisor - Amouli (60%) | $17,701 |
| Nursing Supervisor - Leone (60%) | $18,156 |
| Nursing Supervisor - TFHC (90%) | $28,053 |
| Nursing Supervisor- C2 (40%) | $15,107 |
| Ta'u Clinic Nurse (50%) | $17,026 |
| TFHC Clinic Nurse (50%) | $13,460 |
| Ta'u Clinic Nurse (50%) | $13,062 |
| PH Nurse (Jennings, 50%) | $10,710 |
| C2 Clinic Nurse (50%) | $14,362 |
| TFHC Clinic Nurse (50%) | $11,653 |
| Ofu Clinic Nurse (40%) | $9,345 |
| Leone Clinic Nurse (60%) | $10,832 |
| Physician (40%) | $18,117 |
| Subtotal Local Match Salaries | $229,127 |
| Fringe Benefits | $37,119 |
| Total Salaries + Fringe Benefits | $266,246 |

Title V Positions:
CSN Nurse (100% FTE): Vacant This professional will be responsible for case management and nursing responsibilities for the Children with Special Health Care Needs program. The CSN nurse will work closely with the MCH physicians, nurse practitioners, Public Health nurses in the dispensaries and other health care providers to ensure that all CSHCN clients are re-assessed annually and receive all services recommended in their individual care plans.

2 Community Health Assistant (100% FTE): One CHA currently works at the Amouli dispensary assisting the MCH Practitioners in the Well Baby and Prenatal/Postpartum clinics. The second CHA serves as a dental assistant on the MCH Dental Outreach team.

Data Clerk (100% FTE): This individual is responsible for entering MCH data at the second largest dispensary (Central 2). She was previously a community health assistant with the CSHCN program and with that experience she also assists with the Well Baby Clinic at the Central 2 dispensary.

Dental Assistant: (100% FTE): Vacant This position is requested in order to meet the needs of the MCH Dental Outreach Team. Currently there are 2 dentists but only one dental assistant on the team. A second assistant is requested to enable the dentists to work more efficiently thereby making it possible to serve more children each year.

Dentist (100% FTE): This professional is a member of the Dental Outreach Team who provides preventive and restorative services to children in the schools. The MCH Dentist is responsible for all oral health activities, with emphasis on providing dental sealants to 3rd graders. In FY 2010 the Dentist will also provide services to the CSHCN population. The MCH Dentist provides technical assistance in the development of health education campaign on oral health.

Family Nurse Practitioner (100% FTE): This practitioner is responsible for all medical needs of the MCH population. They provide medical coverage for Well Baby/Child Clinics and the Prenatal/Postpartum clinics, as well as provide home visits to CSHCN for assessments and follow-up. The practitioners also provide technical assistance and training to the MCH and Public Health staff, instructions/health education to parents pertaining to the care of the children particularly CSHCN. They are involved in the establishment of policies and procedures for services provided by Title V as well as the planning process for the Title V programs.

MCH Pediatrician (100% FTE) 2: This physician works primarily in the Well Baby/Child clinics to provide direct health care services to all infants and children who access services at these clinics. The MCH Pediatrician also serves children in the CSHCN needs, provides medical services to the Sexually Transmitted Disease program clients, as well as serves as the Medical Advisor for the Immunization Program.

MCH Nurse (100% FTE): Vacant This position is requested to assist with the Well Baby and Prenatal Clinics at Tafuna Health Center. This is the busiest of all clinics, serving the largest population on the island. Both Well Baby and Prenatal clinics are booked with appointments months in advance due to the number of clients served, yet there are not enough nurses to accommodate the workload. This nurse will assist with patient assessments, immunizations, family planning and prenatal services for both clinics, rotating to accommodate the clinic schedules.

MCH Coordinator (100% FTE): The responsibilities of coordination for the MCH program require a full time person. The coordinator is responsible for organizing program activities, working with various staff members to ensure performance measures are met, collecting and reporting of all data on the National and State Performance and Outcome Measures, submission of the annual report and grant application annually. The coordinator serves in a leadership role in the Department of Health to facilitate and coordinate services for infants, children and their families

primarily served at the various clinics/programs: Well Baby Clinics, Prenatal/post-partum clinics, School Outreach Team, CSHCN Program, Nutrition, Health Education, and other services. The coordinator works with various partners and stakeholders such as the American Samoa Medical Center Authority, Department of Education, Univ. Center for Excellence in Developmental Disabilities, the Developmental Disabilities Planning Council and Interagency Leadership Team, Office of Highway Safety, Gear Up, and the Population Pressure Commission. Currently the MCH coordinator also oversees and coordinates MCH data activities through the SSDI program.

MCH Health Educator (100% FTE): This individual is responsible for all health education activities relative to the MCH population. The Nutrition staff have combined efforts with the Health Educator to provide health education, counseling and outreach on all MCH topics including breastfeeding, importance of prenatal care, pregnancy and infant care, nutrition, obesity prevention and physical activity, etc.

Women's Health Nurse Practitioner (100% FTE): This practitioner is responsible for the women's health services including the Prenatal, Postpartum, and Family Planning clinics. She also provides routine screening and educational services on a variety of women's health issues including cancer screening and education.

Nutritionists 1 & 2 (100% FTE): These professionals provide nutrition and breastfeeding education to clients in the Well Baby/Child, Prenatal/Postpartum clinics at the 5 clinic sites. They also provide education on these topics to postpartum women in the Maternity ward prior to discharge. The Nutrition staff have combined efforts with the Health Educator to provide health education, counseling and outreach on all MCH topics including breastfeeding, importance of prenatal care, pregnancy and infant care, nutrition, obesity prevention and physical activity, etc.

MCH Physician (FTE 100%): This practitioner is responsible for all medical needs of the MCH population. He/she will provide medical coverage for Well Baby/Child Clinics and the Prenatal/Postpartum clinics, as well as provide home visits to CSHCN for assessments and follow-up. The practitioner will also provide technical assistance and training to the MCH and Public Health staff, instructions/health education to parents pertaining to the care of the children particularly CSHCN.

| | | | | |
|---|---|---|---|---|
| SUPPLIES | | | | |
| Medical Supplies for CSN | | | $ | 1,500 |
| Dental screening supplies | | | $ | 3,000 |
| Health Education Supplies | | | $ | 2,000 |
| General Office Supplies: | | | $ | 1,500 |
| Urine dip sticks | $ | 1,000 | | |
| Multivitamins/flouride | $ | 3,000 | | |
| Iron Supplements | | | $ | 3,000 |
| HGB lancets & slides | $ | 3,000 | | |
| SUPPLY TOTAL | | | $ | 18,000 |

Supplies requested include multivitamin and iron supplements for infants, children with special health care needs and children, hemoglobin testing supplies, and health education supplies. The local/state MCH dollars allow for personnel costs only, supplies and other categories come from federal partnerships such as the MCHB/State partnership.

Health Education Supplies: This amount will enable MCH staff to purchase items necessary for health education for the various MCH issues such as prenatal care, breastfeeding, nutrition, and adolescent health.

Iron Supplements: Although hemoglobin testing and physical assessments have shown many children have low hemoglobin levels very few families are able to afford therapeutic iron supplements. Funding is allocated to purchase iron supplements for therapeutic doses for

children with low hemoglobin who cannot afford to buy the supplements.

HGB lancets & slides: Hemoglobin testing supplies are requested for the Well Baby Clinics, to ensure that children receive recommended and routine screenings as part of their check-ups.

Multivitamins/fluoride: American Samoa also lacks water fluoridation and children sometimes do not get the recommended level of nutrients from their diets. For this reason funding is requested to purchase multivitamin and fluoride supplements.

Medical Supplies for CSN: Funds are also requested for medical supplies for Children with Special Health Care Needs team for home visits such as gloves, gauze, ointments, and other necessary items.

EQUIPMENT

| EQUIPMENT | Total |
|---|---|
| Dental screening equipment | $ 4,000 |
| Total | $ 4,000 |

The 2009 budget request includes dental screening equipment for the MCH Dental outreach team. This equipment will be used to provide dental screening and sealants to 3rd grade children meeting National Performance Measure 9. The equipment currently in use is several years old and it is anticipated some of the equipment will need to be replaced and/or repaired in the new school year.

OTHER

| OTHERS | |
|---|---|
| Media costs | $ 5,000 |
| Printing costs | $ 1,000 |
| CSHCN Family Participation | $ 1,500 |
| Staff Development | $ 5,000 |
| CSHCN Assistive Devices | $ 1,000 |
| AMCHP Membership | $ 1,000 |
| Telephone costs | $ 1,000 |
| Prenatal Laboratory Reagents | $ 3,000 |
| LOCAL MATCH | |
| Clinic Facilities: | |
| TFHC | $55,000 |
| C2 | $40,000 |
| Leone | $40,000 |
| Amouli | $34,215 |
| MCH Offices | $30,000 |
| Local Match Total | $199,215 |
| OTHER TOTAL | $229,715 |

Media Costs: The health education program will utilize TV, and Radio to increase awareness of services provided by Title V. The MCH Program maintains advertising contracts with the local media to maximize awareness on such topics as prenatal care, breastfeeding, oral health and physical activity.

Printing Costs: Each MCH Program has printing needs for health education materials and other activities.

CSHCN Family Participation: This amount will be used for CSHCN family participation activities

such as Parent Group meetings, training etc.

Staff Development: In 2010 the MCH Program is sponsoring staff development for the Children with Special Health Care Needs program staff. The Occupational Therapy Aide employed by MCH is currently enrolled in the Occupational Therapy Program at Loma Linda University. For several years the MCH program has made efforts to recruit a certified occupational therapist for the CSHCN program with no success. For the long term benefit of the children served by this program the MCH program is training current staff members in hard to fill positions to meet the needs. This staff member has signed a contractual agreement whereby for each year MCH sponsors her training program she will return to serve a year as an Occupational Therapist for the CSHCN program.

AMCHP Membership: The American Samoa MCH program wishes to continue its partnership with AMCHP.

Telephone Costs: This amount will enable the MCH program to make long distance phone calls as appropriate.

Prenatal Care Lab Reagents: In an effort to make prenatal services more affordable and accessible for women served at the Tafuna Family Health Center, the MCH Program has allocated money to subsidize the lab tests necessary for the first prenatal exam. As cost has been identified as a barrier to prenatal services this cost is included in the 2010 budget.

TRAVEL

TRAVEL
2 persons to travel to the MCH
Grant review in Honolulu

| | | |
|---|---|---|
| Airfare 2000 x 2 | $ | 4,000 |
| Per Diem 2 x 167 x 7 | $ | 2,338 |
| | $ | 6,338 |

Travel funds are requested for the mandatory MCH meetings, the block grant review in Honolulu, Hawaii. American Samoa has experienced an increase in travel cost over the last year. Therefore travel requests are limited to required meetings.

***An attachment is included in this section.***

## VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. Technical Note

Please refer to Section IX of the Guidance.

## X. Appendices and State Supporting documents

### A. Needs Assessment

Please refer to Section II attachments, if provided.

### B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

### C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

### D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.