



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

**State Narrative for
American Samoa**

**Application for 2013
Annual Report for 2011**



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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. IA - Letter of Transmittal

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 January 2012; expires January 31, 2015.

E. Public Input

/2012/

The MCH Program sent invitations out to its partners, stakeholders and consumers to attend a stakeholder meeting. At the meeting the MCH staff went over various aspects of the annual report, the data reported for 2010, and the plan for 2012. The group included members from the medical community, the developmental disabilities community, community coalitions, parents and consumers.

The data reported in the annual report was provided to all present, while the staff presented on the highlights of the plans for each population group served. The document itself was made available for review and comment. The purpose of this meeting was to solicit feedback from consumers and partners alike, as well as create opportunities for collaboration and better coordination across the different services.

Input from this meeting has been incorporated into this document.

//2012//

/2013/ The MCH Program sent out invitations to partners, stakeholder, parents and various stakeholders to attend a data output session/stakeholder meeting. The purpose of the meeting was to share MCH data with our partners and stakeholders, and to ask for feedback planned activities for 2013. The MCH program spends considerable time collecting data, and most of these efforts are done in collaboration with other partners. This also provided an opportunity to share that data with the partners and stakeholders, and to hear what some of the questions and comments were on the data and the draft of the plan to address the MCH Priority areas.

Documents were sent out ahead of time to allow time for review before the meeting. Since then, the information shared along with minutes from the meeting has been sent out to all partners.

Specific questions that were asked at the meeting included:

"How can we strengthen our partnerships?"

"How can we engage our parents and community better?"

"What do we need to do better?"

Feedback received at the stakeholder meeting included the need for more education and awareness for parents and families in the areas of:

- Prevention of negative birth outcomes related to late pregnancy care***
- Breastfeeding***
- Care of chronic conditions in children***
- Growth and development***
- Improving services for newborns and premature babies at the health centers.***

There was good representation by the professional partners/stakeholders, however only a few parents were present. This has been an issue in previous years as well. In order to counter this issue, MCH staff who provide health education in the health centers have been asking parents they encounter for some of their feedback on services they receive, and areas for improvement. Some feedback was received regarding services in the clinic areas and outreach services. These plans have been incorporated into health education plans.

Parent feedback was also received through the Children with Special Health Care Needs Survey done this year. Twenty percent of families enrolled in the program responded to the survey this year. Their input has been incorporated into plans for the CSHCN program including staffing and scheduling changes.

Later this year a strategic planning session has been planned for the MCH Program. It has not been possible to organize before the plan for FY2013 was due, however this will also provide more opportunity to engage stakeholders, parents, and partners in plans for MCH. The strategic planning process will include a more organized and coordinated plan for community engagement in this process. The strategic planning session will be conducted before the beginning of the new fiscal year. //2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2013/

The Department of Health has been in the process of conducting several assessments during this year that has cross cutting impact on all programs. In 2012 an assessment was conducted on the use of Evidence Based Practices (EBP's) within the Department, as part of the Public Health Improvement Initiative. All 19 program areas were assessed using a key informant survey tool, with 100% compliance. The assessment provided an inventory of all types of services being provided by all programs across the Department, and the types of evidence currently being used by each program. While the overall use of EBP's appeared to be low across all programs, it was evident that the programs serving the MCH population were assessed at having a higher utilization rate of EBP's than all other service areas.

The next steps in this assessment process will be to identify which programs/services within the Department of Health not currently using an EBP can most feasibly and successfully be moved towards implementation of an EBP within the next fiscal year. This project will then assist program managers and Department leadership to cross walk the programs from current program implementation to the EBP implementation.

Also within the same period, the Department conducted an assessment of the health information systems (HIS) within the agency and began initial steps towards development of an HIS plan for the Department. The assessment was conducted with technical assistance from the Pacific Islands Health Officers Association, and was completed in August 2012. As data capacity is a vital need for the Department, including the MCH program it is anticipated the work towards developing data infrastructure and information systems capacity will benefit all programs in the Department. A base plan has been set forth and the Department of Health leadership intends to follow through with most if not all of the recommendations set forth in the plan beginning in FY 2013.

The Department of Health also conducted a community based needs assessment process around the very high prevalence of Non-Communicable Diseases in American Samoa. This assessment was conducted with technical assistance and funding from the partnership between the Secretariat of the Pacific Communities and the World Health Organization. This assessment collected data indicators in health, policy, environment, and community resources through quantitative measures. There was also a very significant effort made to include community feedback.

A Community Lifestyle Survey was conducted of over one thousand residents. The survey questions were derived from the WHO Mini Steps survey, so as to provide comparisons with the Steps Survey that was conducted in 2004, and any future Steps surveys to be conducted in American Samoa. The results of these assessment efforts are being compiled into a Strategic Plan to address NCD's in American Samoa. The strategic plan is anticipated to be completed in the Fall of 2012.

In all of these efforts mentioned, the MCH Program played a key role in a leadership and supportive capacity. All of these efforts have direct impact on the infrastructure wherein the MCH Program exists and functions. It is anticipated that the capacities and infrastructure that is developed in these planning efforts will have a direct positive impact on MCH services as well.

III. State Overview

A. Overview

American Samoa is an unincorporated territory of the United States and consists of a group of seven islands in the southern Pacific Ocean located 2,600 miles southeast of Hawai'i and 1,800 miles northeast of New Zealand. The total land area of American Samoa is approximately 76 square miles (200 square km). The main island of Tutuila, the largest island of the group, covers an area of 55 square miles (143 square km) and is home to Pago Pago, the political, administrative, and commercial center of the Territory of American Samoa. Aunu'u Island is one mile off the southeast tip of Tutuila (a 15-minute ferry ride), with a land mass of 0.6 square miles and one village with a population of 476 residents (2000 Census). Sixty miles east of Tutuila is the Manu'a Island group (a 30-minute airplane ride) that includes the volcanic islands of Ofu and Olosega, connected by a bridge, and the Island of Ta'u. These islands are sparsely populated, with a total 2000 Census population of 1,378 residents, and each village having a few hundred residents. The Swains Island is a privately-owned coral atoll located 214 miles north of Tutuila with approximately 1.25 square miles of land mass and a population of 37 residents (2000 Census). Swains Islanders raise coconuts and grow bananas, taro, breadfruit and papaya, and supplement their diet with fish from outside of Swains' reef. Rose Island (coral atoll) lies 78 miles east of Ta'u with a land mass of 0.1 square miles, is uninhabited and is named a national monument.

Based on the American Samoa 2000 Census of Population and Housing (2002), the Territory of American Samoa had a population of 57,291 residents and represents a 22% increase from the 1990 Census of 46,773 residents. Mid-census 2005 population was projected to increase to an estimated 65,500 residents and to 69,200 residents by 2008 and a projected increase to 80,000 by 2010. American Samoa is divided into four geo-political districts: Western District, Eastern District, Manu'a District, and Swains Island District. The population distribution for these districts show that there are 32,435 residents (56.6%) in the Western District, 23,441 residents (40.9%) in the Eastern District, 1,378 (2.4%) in the Manu'a District, and 37 residents (0.06%) in the Swains Island District. Of the total population based on the 2000 Census, there were 29,264 males (51.1%) and 28,027 females (48.9%). In assessing the population distribution by age (Table 1), American Samoa has a relatively young population with over one-third (38.7%) of the population less than 15 years of age. For the total population, the median age stands at 21.3 years with 47.8% of the population less than 20 years of age, 44.1% between 20-59 years, and 8% who are 60 years and above.

Of this total population, 95.8% of the residents reported one ethnicity or race and 4.2% reported two or more races or ethnic groups. Of those who reported one ethnicity, 91.6% reported themselves as Pacific Islanders, 2.8% Asian, 1.1% White, and 0.2% some other race or ethnic group. Of those residents who reported themselves as Pacific Islander, 88.2% are Samoan, 2.8% Tongan, and the remainder are Tokelauan, Fijian, or other Pacific Islander. While the proportion of the American Samoan born population remained above 50%, the foreign-born residents increased from less than 20% in 1960 to over 40% in the 2000 census. The majority of the foreign-born immigrants were from neighboring Samoa with over 30%, the US-born immigrant population was 5 percent.

There are 9,349 households in American Samoa of which 8,706 (93.1%) are family households and 643 non-family households (householder living alone). Of the family households, 6,596 (70.6%) are married-couple families of which 5,261 are households with children under 18 years of age and 1,398 (15%) are female head of household of which 640 have children less than 18 years of age. Of the total households of all types, 7,598 (81.3%) are households with an individual under 18 years of age.

American Samoa has a total land-mass of 70 square miles and an estimated 2008 population of 69,200 residents of which 97.5% reside on the main island of Tutuila the largest island of the

group, that covers an area of 55 square miles (143 square km) and is home to Pago Pago, the political, administrative, and commercial center of the Territory of American Samoa. In addition to the fact that the vast majority of the population of American Samoa is concentrated on one island, the residents of American Samoa are culturally a relatively homogeneous population with a large proportion reporting themselves as Samoan.

Economic Environment

Traditionally the local economy consisted of subsistence farming and fishing. In the 1970's and 1980's the influence of the U.S. mainland standard of living took a significant stronghold in local communities. Since then the concept of subsistence living took a downward trend as young American Samoans left for military services, education and better opportunities on the mainland. Major improvement in the cash economy evidenced by significant increases in exported canned tuna products valuing at over \$400 million annually brought more migrant families from neighboring islands such as Western Samoa and Tonga. Tuna fishing and tuna processing plants are the backbone of the private sector, with canned tuna the primary export. In 1999, the median household income was \$18, 219 and the majority (87.8%) of households earned less than \$50,000, while poverty status was determined for more than half (61%) of the population. In 2004, the median household income was \$22,930 and the mean household income was \$32,028. In 2005, a total of 17,344 people were employed that included 6,064 people employed with the government, 4,546 people employed in the tuna canneries, and 6,700 people employed in the private sector. The overall unemployment rate in American Samoa was 29.8%.

The poverty status for American Samoan residents is high based on U.S. standards with a primary factor being the lower minimum wages when compared to the U.S. In 2008, the minimum wage in the U.S. mainland states was \$6.55/hour whereas the minimum wage in American Samoa ranged from \$3.81/hour for government workers to a high of \$4.99/hour for employees in finance and insurance. The other major industries and their minimum wages include construction workers at \$4.60/hour, fish cannery workers at \$4.26/hour, and retail workers at \$4.10/hour. American Samoa has the lowest per capita income in the entire U.S. system including 3141 counties, 50 states and the other U.S. territories.

In examining the 1999 poverty status of residents, 61% of all individuals in American Samoa are considered to be in the poverty status; and of these, 56.6% are individuals above 18 years of age, 47.9% are individuals 65 years and older, 66.5% are children under 18 years of age. When assessing the poverty status of families in American Samoa for the same time period, 58.2% of the families are below the poverty level and of these families 62% are families with related children under 18 years of age and 67.4% are families with children under 5 years of age.

American Samoa is currently participating in the 2010 US Census. The new census information will be included in the MCH program application as it becomes available.

In 2008, the American Samoa Department of Commerce published a report, American Samoa's Economic Future and the Cannery Industry. The study was undertaken to assess American Samoa's economic future especially in view of possible serious reductions in the tuna cannery operations and plant closures because of U.S.-International trade agreements and expanded foreign competition, the loss of federal tax incentives, and the dramatic increase in the minimum wage that took effect in American Samoa 2008. The report states that with the closure of the tuna cannery, there is a strong possibility that economic distress would remain very high in American Samoa for a long time in the form of very high rates of unemployment, business closures or cutbacks and precipitous declines in local revenues. These conditions could have a variety of adverse effects on the community that includes: (1) Increased family and social stress that often translates into criminal behavior including domestic violence. (2) Declining economic opportunities for youth entering the workforce. (3) Declining local revenues for health, education and general public welfare, as well as investments in capital projects and maintenance. (4) Rising economic dependence on the federal government. (5) Fewer resources to preserve Samoan

culture and the physical environment.

The American Recovery and Reinvestment Act has also provided economic stimulus to the economy through creation of new jobs, construction projects and expansions to various programs. These two events have helped stimulate the local economy and provide jobs however, the long term effects of industry loss and other economic difficulties still remain to be seen.

Cultural and Social Environment

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

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

Christianity is the foremost religion in American Samoa. Churches are embraced as an important component of society. Church leaders are revered in all social, cultural and professional settings. Church groups are among the most organized and well attended non-governmental organizations in the community. Most families and individuals are active participants in a church organization of some fashion.

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

Health Care System

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

The American Samoa Medical Center Authority (ASMCA), the only hospital in American Samoa, provides all acute medical services and includes outpatient clinics as well as inpatient hospital care. The ASMCA provides outpatient care at the Emergency Room, Primary Care Clinic, Pediatric Clinic, Obstetrics and Gynecology Clinic, Surgical Clinic, Medical Clinic, Ear Nose Throat Clinic, Dialysis Clinic, Psychiatry Clinic, Dental Clinic, and the Eye Clinic. The inpatient services include 109 patient beds in six wards: Labor and Delivery, Nursery, Maternity, Internal Medicine, Surgical, Intensive Care, and Psychiatry. The ASMCA also provides all laboratory, diagnostic imaging, and pharmacy services for the entire population. The ASMCA operates as a semi-autonomous agency of the government and is governed by a board of directors whose membership is subject to legislative approval.

The Department of Health is responsible for preventive services to the community. The Department of Health direct care service in the community based health centers. There are six health centers, spread out geographically throughout the island from the two outer clinics in Manu'a, one on the western end and eastern end of the island, one clinic in the central area close to the capital and the Federally Qualified Tafuna Family Health Center in the most populated area of the island. In 2009 Tafuna Family Health Center added two new access points to its service and has now included the Leone clinic on the western tip of the island, and Amouli clinic on the eastern tip of the island.

The Department of Health is also responsible infectious and chronic disease prevention, community nursing services, environmental health, immunization, Public Health emergency preparedness, cancer control and screening, HIV and STD screening, early intervention and newborn hearing, as well as MCH services.

/2012/

Department of Human and Social Services (DHSS) is the Territory's Single State Agency for Substance Abuse Prevention and Treatment. It also serves as the State Mental Health Authority and is the Governor-designated lead agency for Child Welfare Services and Social Services and is the lead agency on underage drinking. This 100% publicly funded agency directs four (4) core agencies, including: 1) Social Services; 2) Women, Infants and Children (WIC); 3) Nutrition Assistance Program (Food Stamps); and 4) the Vocational Rehabilitation Division. The agency operates the Pua Center, a day support facility for persons with serious mental illness, and coordinates its supported employment activities. DHSS has an annual budget of \$18 million, with over 200 personnel and support staff. DHSS provides substance abuse prevention and outpatient counseling to 150 families each year, as well as mental health services, 24-hour emergency shelter services and crisis hotline, victims of crime advocacy, crisis intervention, family support services and subsidized child care for low-income working families.

//2012//

B. Agency Capacity

/2012/

Pregnant Women and Infants

In 2010 the MCH Program completed the needs assessment for the Maternal, Infant, and Early Childhood (MIECH) Home Visiting Program. The process involved the Department of Health (MCH/CSHCN, Immunization, and Early Intervention Programs), the Department of Education Early Childhood Education (Head Start Program), and the Department of Human and Social Services Child Protective Services, Substance Abuse Prevention and Treatment Program, and Child Care services.

A work group was organized to ensure that all three agencies participated in the needs assessment and planning process. The work group consisted of representatives from each of the Departments and services, as well as members from several community coalitions active in the under age drinking initiative spearheaded by the local Strategic Prevention Framework State Incentive Grants. The work group contributed to the final MIECH needs assessment and state plan that was developed. More importantly, this work group has used this opportunity to better coordinate existing services, share common goals, and information, and improve collaboration across services.

The Home Visiting Work group will continue to work together to plan and implement services that serve mothers, infants, children and their families. The work group is currently preparing its Home Visiting plan for year 2 of the project.

The Department of Health will be hiring new staffing for this project, who will be working closely with the MCH staff. A Program Coordinator, a Quality Assurance Specialist, and Home Visiting Supervisor will be hired. These staff will work closely with the MCH staff to ensure all services to the MCH program are planned and delivered organized and coordinated fashion. The two programs will be collocated to ensure coordination and collaboration between services.

CHILDREN AND ADOLESCENTS

Of a total population of 1446 third grade children in public schools in 2010, 656 children were screened and 654 received fissure sealants.

1. Sealant Coverage

The target population for MCH is third grade students, territorial-wide. A total number of 656 third grade students were screened in the school year 2009-2010. Only 45.2% of total third grade students (1446) enrolled in the Department of Education were screened in the school year 2009-2010. Out of 654 students screened, 651 students (99.5%) had at least one permanent molar sealed. Despite the team's hard work and drive to provide a maximum amount of third graders screened annually, this resulted in an overall annual indicator of 45.0 (Table I). This is a slight increase from the year before.

2. Caries Experience

A total number of 526 (80.2%) students had at least one tooth affected by dental caries. This age group ranges from 7 -- 9 years of age and has a mixed dentition of both deciduous and permanent teeth. Every child was given a dental report card to let parents and/or caregiver know about their dental status. It also informs them of any need to take their child for further treatment and why. Those who were complaining of toothaches at the time of screening were treated immediately at school (either by simple dental extractions and/or dental restorations) or referred to the nearest dental clinic (root canal treatments and more complicated dental extractions that may need dental x-rays).

3. School Access and Coverage

There are currently 23 public elementary schools. The dental team was able to carry-out dental services at 12 public schools for school year 2009-2010. The number of days the team remained in these schools ranged from 2 - 4 weeks. Traveling time to schools varied from 30 minutes to an hour. The ASMCA team targeted second and fifth graders and the MCH team targeted third graders.

4. Resources:

The Dental Outreach Team continued as a joined effort between the SCHIP dental team (from the Hospital Dental Services) and that of MCH. A total staff of eleven (11) was assigned to this outreach program. It consisted of four dentists and seven dental assistants.

Supplies and equipment for these outreach efforts are provided by the MCH block grant (MCH team) and the SCHIP program (hospital team). The teams work together at larger schools, in order to complete services for the targeted classes, and for smaller schools the teams work individually to ensure better island wide coverage.

5. Dental Health and Services Public Promotion

i) Social Services Day Care Health Awareness Activities

In October 2009, the MCH staff including its dental team was again invited by the Department of Human and Social Services (DHSS) to take part in raising dental health awareness among

children who were attending Day Care Centers in American Samoa. This was held at the Samoana High School gym. DHSS were giving out balloons and candies for the children so it was only appropriate that the team was there to remind them that even though you can eat candies at special occasions (like Halloween), they also have to remember that they need to prevent tooth decay by brushing flossing daily. More than 600 children and their families attended this celebration. Other agencies present were also there present to promote their services.

ii) Department of Education Wellness Fair

The MCH staff took part in the Wellness Fair held in March 2010. The dental team provided dental screenings, dental report cards and fluoride varnish application. This was held at the Samoana High School's football field in Utulei. Each child was given a dental report card as well as incentives such as a toothbrush and dental stickers. Nutrition and physical activity were promoted by the MCH health education staff. Various government and non-government agencies were also there to promote each of their programs. A total number of 417 were seen.

iii) Gear Up Summer Camp

The MCH staff provided a physical screening including dental screenings for the High School children that attended the Gear Up campo in the summer of 2010. They were also given a reproductive health talk that lasted about 30 minutes. A total of 96 students were seen by the MCH Staff.

1. MCH School-based dental prevention.

Children in elementary schools continued to be screened and receive fissure sealant and fluoride varnish application. Children who require emergency treatments are referred to the hospital dental team for extractions and treatments.

2. Dental Hygiene Education and Promotion

A total number of 3 elementary schools had requested dental health outreach and these provided by February 2011.

/2012/

The Governor of American Samoa created by executive order the Governor's Children's Cabinet on Early Childhood Education. This is aligned with local legislation stating the governor will establish a council to serve as the State Advisory council on Early Childhood Education and Care. The executive order delineates functions of the Children's Cabinet to include:

- Conducting periodic needs assessments on the quality and availability of quality services for children from birth to school entry,
- Identify opportunities and barriers to coordinate and collaborate such services on the local and federal levels,
- Provide recommendations for increasing program participation and enrollment of children in services,
- Provide recommendations for the establishment of a unified data system for early childhood services across the Territory,
- Provide recommendations for professional development and career advancement for professionals who serve this population, and
- Provide territory wide strategic reports, and meet periodically to review recommendations and action necessary based on strategic report.

The governor has also appointed the members of the Children's Cabinet, which include the MCH Coordinator as the representative from the health sector. The other members listed are the Department of Human and Social Services, Early Childhood Education, and MCH partners from the Home Visiting work group. The formal organization of the Children's Cabinet and designation of specific tasks ensures coordination and collaboration for early childhood services, as has already been initiated by the MIECH Home Visiting work group and will continue as the project

progresses.

In the fall of 2010, the Boys and Girls Club of American Samoa launched an after school pilot program. The program focused on providing homework assistance, enrichment programs and mentoring for middle school students from 5th -8th grades. The program was initially piloted in 6 schools this first year.

The Boys and Girls Club of American Samoa (BGCAS) board of directors, led by the First Lady of American Samoa as the chair person called upon various sectors in the community to partner with the BGCAS to implement after school programs for the children at these six schools.

The Department of Health, Department of Human and Social Services, the Gear Up Program, and various sports organizations in the community were brought to the table to plan for the after school activities.

The MCH program took the lead for the Department of Health in this effort. As childhood obesity and nutrition are priorities for MCH as well as other programs within the Department, this was the focus area for the after school project. The BodyWorks (for Teens) curriculum developed by the Office of Women's Health was implemented at the after school programs, along with BMI measurements, and physical activity.

Several Department of Health staff were certified trainers for this curriculum, and implemented two training of trainer sessions to ensure there was a cadre of trainers available. The Office of Women's Health provided the training materials (BodyWorks Toolkits) for all the trainers and participants of this project.

This effort was a partnership with BGCAS, but also with other programs within the Department of Health. The Preventive Block, Tobacco Control, Immunization, and Tuberculosis Control programs were all team members to implement 2 BodyWorks sessions, over a 20 week period, to over 100 students in 6 schools.

Student evaluations of the program showed the participants learned a considerable amount about healthy living, and felt it was important to eat healthy food. They also rated that exercise and eating healthy were important, and they would feel comfortable talking to their parents about this.

The MCH program will continue this partnership in 2012, and will continue to work with the BGCAS to promote healthy living for children and their families through interactive learning activities.

//2012//

C. Organizational Structure

The Department of Health is one of the smaller agencies of government. The Director of Health is appointed by the governor, and subject to confirmation by both houses of the legislature. The Director of Health is a political appointee position, a member of the governor's cabinet and is answerable to the governor.

The Department of Health has taken on new leadership in the form of the new Director of Health. The Department is currently going through a transitional period of reorganization, and the new organization chart is still under construction. A draft of the organizational chart has been attached with the 2011 state grant application; however it is still under discussion. A final version of the organizational chart and other changes within the Department should be finalized by the end of 2010 and will be updated in the next application.

The Department of Health employs just under 200 employees and is a department of the American Samoa Government. The main office is centrally located across the street from the American Samoa Medical Center Authority with community health centers and satellite offices located in other locations.

The MCH Program is one of fifteen federally funded programs operating within the Department of Health. These programs include Immunization, Early Intervention, Comprehensive Cancer Control and Breast and Cervical Cancer screening, Early Newborn Hearing Screening, HIV and STD, Public Health Emergency Preparedness, Tuberculosis elimination, Diabetes Control, Tobacco Control, Preventive Health Block Grant, and Hospital Preparedness. These programs work under the oversight of the Director of Health and his administration. Currently, the programs work parallel to one another with the Director and administration (including Deputy Director and Medical Director) directly above.

The Deputy Director of Health serves as the MCH/CSHCN and SSDI Program Director. In this capacity she provides administrative oversight but also advocates for MCH services at the highest level within the Department of Health. The MCH Coordinator works closely with and is accountable to the Deputy Director for implementation of activities, fiscal management, program monitoring and planning. Working closely with the Director and Deputy Director is the Public Health Administrator. The Programs also work very closely with the medical staff, and at least one physician has been designated to work closely with each program. The MCH employs two doctors and two nurse practitioners, one of whom provides this type of expertise to the program.

Other key service areas within the Department include the community Nursing Services, which provides nursing staff to all of the community based clinics. Environmental Health services are responsible for safe and healthy environments, and food vendor regulations and enforcement.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Title V includes administrative staff who provide oversight and administrative direction, the MCH Coordinator who is responsible for program coordination, as well as clinical and support staff:

Tuiasina Dr. Salamo Laumoli, DO, MPH
Director of Health

Tuiasina Dr. Salamo Laumoli practiced dentistry in American Samoa for over 20 years at the American Samoa Medical Center Authority (ASMCA). He was service chief of the Dental Clinic at ASMCA for many years before his retirement and has a MPH from the University of Hawaii School of Public Health.

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. As MCH Program Director she provides direct supervision of the MCH Coordinator, as well as provide fiscal and programmatic oversight.

Ms. Jacki Tulafono, BS
MCH Coordinator

Ms. Tulafono has worked in the MCH Program since 1997 first as a special project coordinator and now as the Program Coordinator. She is responsible for management and effective coordination of program planning, implementation and monitoring. She provides leadership to the MCH staff, is an advocate for MCH issues within the Department of Health and in intergovernmental and public settings, and serves on a number of councils and work groups to

facilitate partnership and cross-collaboration between service providers. Ms. Tulafono is also responsible for the SSDI program and all MCH reporting requirements.

Anaise Uso, BDS - MCH Dentist,

Dr. Anaise Uso is the MCH Dentist who coordinates the MCH School Outreach team. Dr. Uso spends nine months of the year providing preventive health services to school children. She works collaboratively with the outreach team of the ASMCA Dental Services to provide preventive dental services to school aged children. Dr. Uso also works closely with MCH providers to plan and implement oral health activities at the Well Baby and Prenatal Clinics. She also serves in an administrative capacity with program planning and other MCH infrastructure building activities and represents the MCH Program on various councils and committees.

Ipu Eliapo, OTA
CSHCN Program

Ms. Eliapo has worked with the CSHCN program for several years before leaving island to work on her Master's of Occupational Therapy. She has one more year to complete her certifications and will return to provide OT services to children in the Territory.

Saipale Fuimaono, MBBS
MCH Physician

Dr. Fuimaono is a graduate of the Fiji School of Medicine and is the primary physician for the MCH Program. Dr. Fuimaono was hired to provide direct medical services to the second most populated Well Baby/Child clinic on the island. Additionally, Dr. Fuimaono has provided gap filling medical services for Children with Special Health Care Needs. Dr. Fuimanon also provides clinical expertise in policy and standard development as well as resource for health education.

Olita Laititi, MBBS
MCH Physician

Dr. Laititi is a graduate of the Fiji School of Medicine and is the primary physician for the MCH Program. She provides direct medical services to the infants and children who access the Well Baby/Child Clinic at the Tafuna Family Health Center. She serves the most populated clinic on the island. Dr. Laititi also provides clinical expertise in policy and standard development as well as resource for health education.

Margaret Sesepasara, BSN, MSN
Nurse Practitioner

Mrs. Sesepasara serves as the women's health clinical provider at the Tafuna Family Health Center. She provides prenatal, post-partum, family planning and other women's health services to women who access services at the Tafuna clinic. She also acts as an active educator, coach and advocate for breastfeeding and nutrition.

Tele Hill, NP
Nurse Practitioner

Mrs. Hill is the primary clinical provider of services for Children with Special Health Care Needs. She provides direct services to children and their families at home, school or other settings as is necessary. She also provides Well Baby and Prenatal Care services at the eastern clinic in Amouli. She provides follow up for all high risk and chronic care patients being discharged from the hospital. She works closely with Special Education, Early Intervention, and other community partners to ensure that all CSHCN are seen and re-assessed on an annual basis.

Rosita Alailima-Utu, BSN

Mrs. Utu is the senior health educator for the MCH Program. She helps coordinator health education efforts in all areas of maternal and child health. Mrs. Utu works directly in the clinics to provide health education in both group and individual settings. She also provides breastfeeding mentoring and coaching to new mothers.

Mary Time, LPN

Women's Health Nurse

Mrs. Time has many years' experience working in the Family Planning clinic providing education and contraceptive services. She is now also working in the Prenatal/Post partum clinic by providing contraceptive education and services, as well as Hepatitis B vaccinations. She also provide women's health education in this capacity.

Luana Leiato,

Nutrition Educator

Mrs. Leiato is one of the education team, with emphasis on breastfeeding, nutrition and physical activity. Luana works primarily out in the clinics to provide health education in the areas of women's and child health. Mrs. Leiato is one of the certified trainers for the BodyWorks curriculum. She works very closely with Mrs. Utu and Mrs. Alailefaleula.

Conference Alailefaleula,

Nutrition Educator

Mrs. Alailefaleula is one of the education team, with emphasis on breastfeeding, nutrition and physical activity. She works primarily out in the clinics to provide health education in the areas of women's and child health. She works very closely with Mrs. Utu and Mrs. Leiato.

Anetta Pele, Temukisa Sauni, Faafetai Meleisea

Community Health Assistants

These three individuals are health assistants who work in three different areas. All have received training similar to that of a certified nurse's assistant for clinical services such as taking vitals and providing health education, as well as data collection and entry.

Vacant Positions:

MCH Nurse -- to assist with work load at the Well Baby Clinics

Dentist -- to work with the School Outreach Team providing 3rd grade dental sealants

Dental Assistants (2) -- to work with the School Outreach Team

Nutritionist -- to fully staff health education team addressing MCH education issues.

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. The Department of Health MCH Program has long standing working

relationships with all of these agencies and has included these agencies in the recent Title V Needs Assessment just

completed. Each of these agencies are also members of the MCH Advisory Council to ensure that all MCH services

are well coordinated and to enable the pooling of resources and information across agencies.

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; while the two new access points are located at the far east and far western ends of the island.

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.

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

a) Management of Information Systems (MIS) Department 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 Department of Health has a signed MOU with ASMCA and the MCH Information Systems project to share access and resources around the electronic medical records system currently in use. MIS also provides technical and administrative support to ensure data linkages and sharing of electronic medical records system.

b) The OB/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.

d) Title XXI - Family Planning - Provides family planning services to the population of Title V. 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, 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.

e) The Dental Clinic and the Department of Health has a collaborative program to provide free preventive dental services to school children whereby the Dental Clinic provides dentists and dental assistants to coordinate with MCH personnel during the school year for outreach dental services targeting 3rd grade and Head Start children in the Territory.

f) Pediatric Department 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 87% of the population has incomes at or below 200% of the federal poverty level. 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.

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 MCH Coordinator is the Department of Health representative to the First Lady's youth substance abuse prevention initiative (Taitaitama) executive board to coordinate services for adolescents. Members of the DHSS staff are also on the MCH Advisory Council to ensure service coordination and stakeholder buy in. 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) Teen Substance Abuse Prevention Program -- serves the adolescent population of the Territory through community-based coalitions and government agencies including MCH focusing on preventing the use of alcohol and tobacco and illicit drugs among school aged teens.

d) Child Protective Services (CPS) -- The Department of Health is working closely with CPS on the interagency collaborative for MCH Home Visiting Program to provide child protective services to families deemed as high risk and eligible for home visiting services.

e) Substance Abuse Counseling and Treatment - The Department of Health is also working collaboratively with substance abuse services on the interagency collaborative for MCH Home Visiting Program to provide these services to families deemed as high risk and eligible for home visiting services

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. Members of DOE are also on the MCH Advisory Council. The following divisions of the Department of Education directly serve the Title V population:

a) Office of Curriculum, Instruction and Accountability (OCIA)-- MCH staff work very closely with OCIA staff to plan and coordinate health activities implemented with the schools. These activities include child obesity prevention activities, the annual wellness fair, nutrition work group, and discussion of the YRBS survey implemented by OCIA at

the schools.

b) Early Childhood Education - Assists in the enforcement of the Immunization law prohibiting children from 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.

d) 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.

5. 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.

6. 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.

7. AMERICAN SAMOA COMMUNITY COLLEGE -- The Department of Health has fostered several working relationships with programs from the local community college. The MCH Program has a Memorandum of Understanding with the Gear Up Program, and also works closely with the Community Natural Resources Department Nutrition and Research divisions. ASCC also has membership on the MCH Advisor council.

a) Gear Up - The Department of Health has been an active partner in the Gear Up Program for five years. Gear Up is a cohort college preparatory program for underserved children. Gear Up provides educational support to its cohort, now in the 11th grade to increase their success in both high school and college careers. Social supports are provided by Gear Up partners such as Department of Health and Department of Human and Social Services to address health and social issues for these children and their families.

b) Community Natural Resources (CNR) -- Department of Health works closely with the CNR Research division on a number of research projects in MCH. One of the more prominent research projects is Dr. Don Vargo's childhood obesity study that has been published and is now widely used in the Department of Health. CNR

also has the Expanded Nutrition Program that promotes health cooking and vegetable gardening in the community. MCH coordinates activities with both of these divisions to promote healthy nutrition, physical activity and to share data sources.

8. The Department of Health continues to partner with the Department of Public Safety, Office of Highway Safety (OHS).

The MCH program is partnering with OHS to plan an injury surveillance system, as well as activities to prevent motor vehicle related injuries and deaths to all MCH populations.

9. Boys and Girls' Club - MCH will continue to utilize its partnership with the BGC to assist in designing appropriate programs catering to youth of today. It will be religion and culture a sensitive. Another important aspect is planning to look into utilizing technology (internet) as a media for health promotions.

F. Health Systems Capacity Indicators

//2013/

Reporting on the Health Systems Capacity Indicators remains a challenge given the current reporting systems in use in American Samoa. While coding has improved over the past year at the hospital, reporting of the data to the Department of Health remains an administrative challenge. Due to the unique administration of the Medicaid program in the Territory, individual eligibility is not assessed and therefore comparisons cannot be made by insurance coverage. The data reported for indicators on health insurance coverage are however the number of individuals served by MCH or other public health agencies.

//2013//

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2011/

Program priorities that were identified in the prior needs assessment were maintained during the last 5 year period. Many of these issues have been converted into new priorities and state performance measures as they remain to be of concern and warrant effort.

Following the prioritization process of all areas of need identified there was careful examination of each need, the service capacities to address the need, including current efforts as well as gaps, and the effectiveness and/or impact of services. The list of priority needs is a result of a lengthy discussion of all partners assembled at the final needs assessment planning session.

Some priorities weighed more heavily in the discussion than others. For example, immunization was selected after a discussion on the effectiveness of the interventions and the resources allocated for the intervention. Others, such as teen pregnancy, were not chosen because the group decided that it would continue to be addressed as a national performance measure and did not warrant additional importance.

The MCH Program recognizes that adolescent health issues were not highlighted in the plan for the coming year. It is also acknowledged that the capacity to address adolescent health issues is not adequate to meet the needs of this population. Current efforts will continue such as outreach activities to Gear Up students and the Teen Pregnancy Prevention Coalition. The capacity to meet the needs of teens in American Samoa will continue to be developed through infrastructure building efforts and policy development.

//2011/

/2013/

One of the leading health concerns facing American Samoa now is the burden of Non-Communicable Diseases on the population. The magnitude of this issue has changed the scope of the problem from a health issue to a developmental issue. The burden of NCD's on the local society will begin to drain not only health budgets, but economic development and productivity will also begin to suffer.

Childhood Obesity was also an issue that was discussed at the last MCH Needs Assessment; however a clear intervention was never identified. This topic continues to be a top priority, and is being addressed in program activities such as health fairs, nutrition and physical activity education and outreach activities, and nutrition and breastfeeding education for prenatal and postpartum clients.

The MCH staff is also providing a leadership role in the NCD needs assessment and strategic planning activities. As the prioritization and plan take form, it is apparent that any strategies to address this issue will have to focus on the family unit as well as cultural practices.

B. State Priorities

The program priorities as identified and ranked during the 2010 Needs Assessment were:

PRIORITY NEEDS

Increasing immunization coverage for young children.

Increasing adequacy of prenatal care for pregnant women.

Improving BMI of children 2-5 years old.

Improving nutritional status of 1 year olds.

Increase the number of infants who are breastfed.

SERVICE LEVEL

Population-based

Direct Services

Enabling Services

Direct/Enabling Services

Direct/Enabling Services

Improve oral health of children 0-5 years. Population-based
 Improve services for Children with Special Health Care Needs. Direct Services

These priorities were used to develop State Performance Measures. Most of the priorities are directly addressed in the State Performance Measures. Although not all priorities are included as State Performance Measures (such as oral health and breastfeeding), these priorities are addressed in the National Performance Measures. Efforts to address those needs are included in discussion of the National Performance Measures.

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	2007	2008	2009	2010	2011
Annual Performance Objective	10	0	0	0	0
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1291	1338	1361	1194	1287
Data Source		Newborn records	Newborn records	Newborn records	Newborn 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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011

NA - American Samoa does not have a state mandated newborn screening program. In Form 6, a total number of 1171 infants (90.8% of live births) were screened for Hearing.

Notes - 2010

Despite the fact that American Samoa does not conduct metabolic screening, there is ongoing hearing screenings for newborns before hospital discharge. The Early Hearing and Detection Intervention Program (EHDI) reported that they had conducted hearing screenings for 88.3% of all newborns in 2010. Part C reported that 77% of those screened initially passed the test. Those who did not pass the screening (23%) were reappointed for additional screenings (and possible audiological evaluation) and are then referred to the American Samoa Early Intervention Program (ASEIP) for early intervention services. Both EHDI and ASEIP are under Part C.

Notes - 2009

American Samoa does not have a state mandated newborn screening program.

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. The MCH staff is working with the pediatric department of the hospital to do some preliminary research into this topic, convene a work group to review all information and make some recommendations on how to move forward towards offering screening.	X			
2.				
3.				
4.				
5.				
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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 currently have a legislated newborn hearing screening program, and currently metabolic screening is not conducted. This topic has been discussed at stakeholder meetings and there is a growing interest in what is required to offer newborn screening. To capitalize on this interest the MCH staff will work with the pediatric department of the hospital to do some preliminary research into this topic, convene a work group to review all information and make some recommendations on how to move forward towards offering screening.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	1287					
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	0	0.0	0	0	0	
Congenital Hypothyroidism	0	0.0	0	0	0	

(Classical)						
Galactosemia (Classical)	0	0.0	0	0	0	
Sickle Cell Disease	0	0.0	0	0	0	
Hearing Screening	1171	91.0	4	0	0	

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	2007	2008	2009	2010	2011
Annual Performance Objective	45	90	90	75	77
Annual Indicator	89.3	89.3	75.0	75.0	88.6
Numerator	125	125	30	30	39
Denominator	140	140	40	40	44
Data Source		CSHCN Program records	CSHCN Program Survey	CSHCN Program Survey	CSHCN Program Survey
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?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	90	90	91	91	92

Notes - 2011

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

Notes - 2010

This data is based on the survey carried out in 2009 by the Children and Youth with Special Health Care Needs Staff. The team implement this survey every two years. Challenges are related to the shortage of personnel and the difficulty in hiring a nurse and therapists. Ms. Ipu Eliapo had just completed her master's degree in Occupational Therapy and had started working early July, 2010. It is with optimistic anticipation that her presence will improve quality of services delivered as well as feedback from clients and their families.

Notes - 2009

This data was reported by the CSHCN team after completing a telephone survey of 40 families. This is 27.4% of the total CSHCN population. Results showed that over half of those surveyed were very satisfied, 18% were somewhat satisfied, 7% were not satisfied.

a. Last Year's Accomplishments

The survey of families with CSHCN this year reported of the respondents, 88.6% were satisfied with the services that were received by the CSHCN program. The CSHCN staff strives to partner with families and parents in the delivery of services planned and accessed for each child. Parents often consult the CSHCN staff for various needs, even those not relating to health care. The CSHCN staff make every effort to link families to needed services available in the community and will work with other service providers to ensure needs are met.

This year has been a challenge due to lack of staffing. The CSHCN clinician has partnered with the MCH dental outreach team and the Health Education team to provide a team approach to service provision to counter this challenge. This approach has worked well for those children and youth in the school setting. The CSHCN staff has also partnered with other service providers such as Helping Hands (Early Intervention), the Division of Special Education, and the University Center for Excellence in Developmental Disabilities to coordinate services for children, youth and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In the process of hiring new staff for the CSHCN Program to include a Service Coordinator and a Community Health Assistant				
2. Families are contacted via telephone or informed during homevisits as well as in school visits to ensure that they partner in decision making at all levels and are satisfied.				
3. Work with its partners to include the Developmental Disabilities Council, University Centers for Excellence in Developmental Disabilities, and the Interagency Leadership Council, and the Center for Individuals with Developmental Disabilities to coord				
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10.				

b. Current Activities

The current activities for CSHCN Program primarily focus on staffing issues in order to serve all of our families. The Occupational Therapist that was off island for continuing education has returned and resumed work, providing much needed manpower to this program. The current services include partnership with the pediatric department at the hospital to follow up on infants and children who are referred for services, as well as outreach to visit children in their homes and schools to provide service.

Currently the MCH staff is working on the agreement with the Division of Special Education to plan for services for next year. A Memorandum of Agreement is currently in place and will be revised to reflect the plan for service provision for next year.

c. Plan for the Coming Year

The plans for the coming year include hiring of new staff for the CSHCN Program to include a Service Coordinator and a Community Health Assistant. With two new staff the program will then have better capacity to provide coordinated and organized services to all children known and referred to the program.

The CSHCN staff will also work with its partners to include the Developmental Disabilities Council, University Centers for Excellence in Developmental Disabilities, and the Interagency Leadership Council, and the Center for Individuals with Developmental Disabilities to coordinate family/parent workshops to engage parents for both educational sessions but also for soliciting feedback into the delivery of services for CYSHCN in the community.

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	2007	2008	2009	2010	2011
Annual Performance Objective	65	90	90	100	30
Annual Indicator	89.3	89.3	20.0	20.0	79.5
Numerator	125	125	8	8	35
Denominator	140	140	40	40	44
Data Source		CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
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?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	81	82	83	84	85

Notes - 2011

The denominator is the total number of clients that were interviewed.

Notes - 2010

This estimate is based on the 2009 survey.

Notes - 2009

This data was reported by the CSHCN team after completing a telephone survey of 40 families. This is 27.4% of the total CSHCN population. 20% of those surveyed reported that services were coordinated and comprehensive within a medical home.

a. Last Year's Accomplishments

The Children with Special Health Care Needs team (CSHCN) has continued to provide physical examinations to clients in the CSN program. There have been clients who have not had annual assessments due to having relocated off island, or their medical issues have been resolved through medical or surgical treatment. The CSN staff has continued to attend Grand Medical Rounds at the American Samoa Medical Authority Center (LBJ), Pediatric Ward/Nursery/ICU areas. Discharge planning and referrals from these areas if there are special needs are referred

to the program.

The CSHCN team has continually worked with the Helping Hands, in particular the Physical Therapist in scheduling / visiting for follow up clients. There is an increase in the number of caregivers/parents whom are receiving more coordinated system of care and may have led to the increase percent of those interviewed providing a positive feedback. These visits are coordinated and organized to assist with any medical physical needs of the clients and families.

The CSHCN team has worked throughout the school year with the MCH Dental team. The Department of Education, Special Education (SPED), has worked with the CSHCN in scheduling visitations to High Schools and collaborated home visits.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All clients seen are referred to the nearest Health Center or Hospital when needed.				
2. All clients information are updated with nurses and physicians at their medical home to ensure that their files and records are up to date.				
3. The CSHCN staff has continued to partner with different service arms of the Department of Health to ensure that services to program enrollees are implemented.				
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b. Current Activities

The CSHCN team continues to assist all clients and their families, providing annual evaluations. A few clients were discharged once they become of age or have resolved their medical issues through various treatments or surgeries. The CSHCN team has been working closely with the Helping Hands (early intervention) program, carrying out home visits for the CSHCN even on weekends when it is best for the families.

The staff from the Special Education Department (SPED) has also been very instrumental in coordinating home visits for children who have not been able to attend school due to a health issue. Students who have been missing school are visited by the CSHCN team, through coordinating efforts by Special Education and Department of Health staff.

c. Plan for the Coming Year

The CSHCN staff has continued to partner with different service arms of the Department of Health to ensure that services to program enrollees are implemented. The program staff primarily serving the CSHCN clients are the Health educator, MCH Dental Outreach Team and the Helping Hands (early intervention) Team.

Efforts to strengthen coordination and partnership with the Community Health Centers will also be emphasized in the coming year. Better coordination with community based services is needed to

improve the service systems for Children, Youth with Special Health Care Needs. The MCH staff will also make efforts to work with the pediatric department at the hospital to coordinate referrals, follow up, meeting recommended services in timely manner, as well as education and awareness activities.

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	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	140	136	146	146	44
Denominator	140	136	146	146	44
Data Source		CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
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?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2009

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.

a. Last Year's Accomplishments

Health care system in American Samoa is very unique, and does not operate on an insurance based system. Therefore this measure does not hold the same significance in American Samoa as it does elsewhere.

While American Samoa law mandates that all residents have access to medical services and cannot be charged for medical services per se, the service providers have instituted a facility usage fee in order to generate revenue for operational costs. This fee is minimal when compared with the cost of service, but sometimes burdensome to families who are very low income. However, no one is denied service based on payment. Services are available to everyone and subsidized by Medicaid as it is implemented in American Samoa.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Program continues to be involved in planning around the health insurance situation in the Territory.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently the Department of Health is working closely with the governor's office and the territorial Medicaid/Medicare office to ensure that those who are in greatest need have access to the services they need. There are plans to amend the state Medicaid plan, that has not been amended in quite some time, to ensure families such as those with children with special health care needs have access to necessary services without the barrier of cost.

c. Plan for the Coming Year

MCH Program continues to be involved in planning around the health insurance situation in the Territory. The MCH Coordinator continues to work closely with the Department of Health administration on this issue for all services for children, to include services for children and youth with special health care needs.

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	2007	2008	2009	2010	2011
Annual Performance Objective	60	43	43	45	75
Annual Indicator	42.9	42.9	75.0	75.0	86.4
Numerator	60	60	30	30	38
Denominator	140	140	40	40	44
Data Source		CSHCN Program	CSHCN Program Survey	CSHCN Program Survey	CSHCN Program
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?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	87	88	89	90	91

Notes - 2010

Estimated data is based on the 2009 survey.

Notes - 2009

This data was reported by the CSHCN team. The same percentage of those who reported satisfactory with services they received, also thought that the community-based service systems were also organized.

a. Last Year's Accomplishments

The CSHCN staff have worked to include the health center staff on home visits to CSHCN in their districts. This is to ensure that families become familiar with the staff at the health centers/dispensaries, and that health center staff know the children and families in their catchment area as well as the location of where they live. It has been noted in the past that these families are often very transient, and move between health center districts. This causes difficulty in trying to track them for the continuity of services.

The CSHCN staff also work to ensure families are aware of the services available to them at the health centers, to make services more accessible to them. Dental services are available at the health centers and when possible clients are encouraged to use the services that are closer to them for their convenience. Both the CSHCN and MCH Dental Outreach team coordinate with the health center Dental staff to coordinate these services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In the process of hiring new staff for the CSHCN Program to include a Service Coordinator and a Community Health Assistant				
2. The CSHCN staff will also work with its partners to include the Developmental Disabilities Council, University Centers for Excellence in Developmental Disabilities, and the Interagency Leadership Council, and the Center for Individuals with Developme				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH staff continues to partner with other programs within the Department of Health such as the health centers and Helping Hands to deliver services to the CYSHCN in each district. The CSHCN also works closely with the pediatrics department of the hospital for referral of cases who require follow up after discharge.

The MCH staff also works with other agencies in the community to ensure that services are better coordinated. These services include education and other social services that are needed by

CSHCN and their families.

The CSHCN program continues to work with parents and families in stressing the utilization of the health centers closest to their homes for care. It is not only less expensive for travel but less waiting time for care. Unfortunately not all services are decentralized. Services such as pharmacy and lab are only available at the main hospital. The CSHCN team continues to encourage families to visit the health centers closest to their homes for non-urgent care. Efforts to implement an electronic health records at all health centers and the hospital enables patients to access care from any point, ensuring continuity of care while minimizing unnecessary tests and ordering.

c. Plan for the Coming Year

The plans for the coming year include hiring of new staff for the CSHCN Program to include a Service Coordinator and a Community Health Assistant. With two new staff the program will then have better capacity to provide coordinated and organized services to all children known and referred to the program.

The CSHCN staff will also work with its partners to include the Developmental Disabilities Council, University Centers for Excellence in Developmental Disabilities, and the Interagency Leadership Council, and the Center for Individuals with Developmental Disabilities to coordinate family/parent workshops to engage parents for both educational sessions but also for soliciting feedback into the delivery of services for CYSHCN in the community.

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	2007	2008	2009	2010	2011
Annual Performance Objective	50	22	23	63	65
Annual Indicator	21.4	21.4	61.5	61.5	0.0
Numerator	30	30	8	8	0
Denominator	140	140	13	13	10
Data Source		CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program
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?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	6	7	8	9	10

Notes - 2011

None of the parents/caregivers reported that their 16 to 18 years old teen perceived that their child received any services to transition to adult life.

Notes - 2010

This data was reported by the CSHCN team. It is reported that 13 clients were identified as youth in need of transition. Only 8 clients were successfully transitioned. The CSHCN team includes partners from Department of Education, Social Services as well as medical providers in planning and implementing the transitional phase. Families and caregivers are also included in all decision makings.

Notes - 2009

This data was reported by the CSHCN team. It is reported that 13 clients were identified as youth in need of transition. Only 8 clients were successfully transitioned.

a. Last Year's Accomplishments

According to the CSHCN Survey, none of the clients were transitioned. The transition for health care services for YSHCN is fostered by the CSHCN staff. CSHCN and their families are encouraged to use the services available at the community health centers. At the age a youth with special health care needs transitions to adult care, they are normally already known to the health center staff and will continue to access services there.

Youth transition from pediatric to adult medical services at the age of 15. An adolescent at this age who requires medical care from the hospital is normally accompanied by the CSHCN clinician to the internal medicine clinic at the hospital for their initial visit. If things proceed well after that visit, then the CSHCN staff will only accompany the next visit if requested or if an appointment is missed the CSHCN staff will follow up to ensure the appointment is re-scheduled for a date more suitable.

Only a few YSHCN transition each year, however the transition process has room for improvement.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Revise the policies and procedures for the CSHCN program				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Transition services are an important component of CSHCN services. The CSHCN staff will continue to work with YCSHN and their families to facilitate a smooth transition process. The transition to adult health services will also be arranged with the health centers, where the clinics are not as congested. A total of 15 clients were identified this year that needs transitioning.

c. Plan for the Coming Year

During this next year the MCH staff will be revising the policies and procedures for the CSHCN program. Transition processes will be included in these policies and procedures, and will be reviewed in collaboration with other service agencies to ensure the process is well coordinated and documented for families as well as service agencies.

The plans for the coming year include hiring of new staff for the CSHCN Program to include a Service Coordinator and a Community Health Assistant. With two new staff the program will then have better capacity to provide coordinated and organized services to all children known and referred to the program.

The CSHCN staff will also work with its partners to include the Developmental Disabilities Council, University Centers for Excellence in Developmental Disabilities, and the Interagency Leadership Council, and the Center for Individuals with Developmental Disabilities to coordinate family/parent workshops to engage parents for both educational sessions but also for soliciting feedback into the delivery of services for CYSHCN in the community.

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	2007	2008	2009	2010	2011
Annual Performance Objective	72	73	70	60	75
Annual Indicator	69.7	68.9	56.0	74.3	81.9
Numerator	1667	1540	540	923	1346
Denominator	2390	2234	965	1242	1643
Data Source		Immunization Coverage Survey	Well Baby Clinic records for Amouli, Tafuna and Le	Immunization Program	Immunization Program
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?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	83	84	85	86	87

Notes - 2010

This data improved from 2009 because the American Samoa Immunization Program (ASIP) finalized their survey of Well Baby Records at the end of August, 2011. The ASIP have been increasing community outreach efforts by utilizing their mobile van during week-ends as well as opening the clinics afterhours. The only reason why the objective for this year, 60, had decreased

from the projected 70 in 2009 was because of the drop in the 2009 annual indicator to 56. Next year, it is hoped that the objective will remain at 75 or higher.

Notes - 2009

This data was generated from the community health centers' Well Baby Clinic records, in Amouli, TAFuna and Leone. The ASIP have yet to finalize their report for their 2009 survey.

a. Last Year's Accomplishments

In the past few years the Immunization Program has focused a considerable amount of resources into the assessment of the immunization coverage of early childhood age groups. A Territorial island wide household survey was conducted and the coverage rate for 19-35 month olds was 75%. A manual data collection effort was done of all clinic records and the coverage rate of the same age group was 69%.

These rates were consistently low and are the reason immunization coverage was identified as one of the priority needs for MCH. Plans to increase coverage were made to the Centers for Disease Control and Prevention. Request for additional funding and resources was approved and resulted in a multi-faceted approach for community outreach and awareness campaigns. The low coverage rates were partially attributed to the high volume traffic in the two larger clinics, and low level of nursing staffing. For this reason new efforts and resources focused on services that were above and beyond what has been offered in the clinics.

Outreach activities included extended clinic hours to offer services later into the evening, providing services from a mobile unit at various locations island wide such as sporting and community events, and at popular shopping and eating venues. A mass media campaign was also launched to include radio, television newspaper and billboards.

These efforts have resulted in a significant increase in the coverage rate reported for 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Back to school after-hour clinics.	X			
2. Multi-media campaign.		X		
3. Vaccine Providers and MCH Health Educators are given quarterly in-service trainings which include Immunization updates.		X		
4. The Department of Health also partner with other agencies such as DOE and Day Care Centers, by allowing Immunization staff to visit their facilities and institutions to review records and refer children for shot updates.				X
5. The immunization carried out a survey of immunization records in the Health Centers to determine data for this measure.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program continues normal program activities which include partnerships with the Head Start Program, the Child Care program and various community organizations. Assessment of records is conducted at child care centers, head start and at school registration.

Children who are delinquent are referred to the local health centers to receive the age recommended immunizations.

Prior to school starting in the fall, the Immunization Program launches a Back to School promotion to encourage parents to bring their children in for their vaccinations before school registration.

The Immunization program also partners with the Child Care Program to offer education to child care providers on completion of age appropriate immunizations for the child care eligible children. Additionally, the program also partners with WIC to ensure that eligibility workers are able to read the immunization cards and make the appropriate referrals to the health centers for immunizations.

Other program activities include:

1. Multi- media campaign.
2. Documenting and Generating reports from data in the Web-based registry.
3. Community Outreach during health fairs and stations at public parks, giving out flu shots and promoting and updating families of infants and children about their immunization shots.
4. Regular inservices for nurses to keep them up to date with appropriate policies and procedures.

c. Plan for the Coming Year

Along with direct services in the health centers to provide vaccinations, the MCH and Immunization Programs continue to work on development of electronic record systems to ensure availability and portability of health records. The efforts to work on the electronic records will continue in 2013.

Also in the coming year, the program has been awarded funds to purchase the mobile unit that was previously on lease with ARRA funds. This will ensure that outreach activities will continue, and efforts to reach a higher coverage rate continue.

Immunization coverage remains a priority for MCH and the Maternal, Infant and Early Childhood Home Visiting Program. These programs will continue to partner with the Immunization Program to ensure complete coverage for all enrollees of the Home Visiting Program in 2013.

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	2007	2008	2009	2010	2011
Annual Performance Objective	11	10	14	18	17
Annual Indicator	14.8	15.6	18.9	17.6	29.2
Numerator	27	29	29	27	44
Denominator	1828	1856	1535	1535	1507
Data Source		Vital Statistics	Labor and Delivery Logbook and Vital Statistics	Vital Statistics	Vital Statistics
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
	2012	2013	2014	2015	2016
Annual Performance Objective	29	28	27	26	25

Notes - 2011

This data is provisional and will be finalized once data is accurately determined.

Notes - 2010

The denominator is an estimate from 2009.

a. Last Year's Accomplishments

The MCH Program continues to partner with the Teen Pregnancy Prevention Coalition and the Family Planning Program. The Nurse Practitioners and health education staff also partner with the Office of Youth and Women's Affairs and the outreach activities scheduled in various community settings. These outreach sessions are opportunities for health education on a variety of topics to include teen pregnancy and other MCH topical areas.

There has been an increase this year in teen births. This is a very culturally and socially charged issue and it is often difficult to address. In outreach sessions the approach is around strengthening the family bond and improving communication between teens and parents. The message of the Teen Pregnancy Prevention Coalition is to return to the foundation, which is family, culture and religion. This message is more culturally, and socially acceptable. Contraception is not immediately discussed, of course when teens or parents request this information it is always provided.

Contraception services are still available at all health centers as well as the Family Planning Clinic, and anyone can walk in. The teens are not always willing to access these types of services for fear of discovery by their parents or others they know. Multi-media messages on prevention of teen pregnancy continue to be broadcasted.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with the Boys and Girls Club to implement programs for teens that address adolescent health issues such as teen pregnancy and suicide.				
2. Collaborate all planning efforts with Teen Pregnancy Prevention Program.				
3. The Teen Pregnancy Prevention Program held a workshop meeting with the community to promote efforts and plan for upcoming year.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

There were plans to coordinate with the Gear Up program to offer adolescent health education and services. Gear Up has come to the end of its demonstration period, and the cohort of students has graduated from high school. This group of students will not be followed beyond this year.

c. Plan for the Coming Year

Teen pregnancy will be addressed as a component of the overall adolescent health program to be used in 2013. The MCH staff will coordinate with the Boys and Girls Club to implement programs for teens that address adolescent health issues such as teen pregnancy and suicide.

The MCH staff will offer Life Skills to the Boys and Girls Club. This is an evidence based curriculum focusing on communication, coping skills, social skills, and other mechanisms teens can use to cope with issues they face on a daily basis. The curriculum has a section for both teens and parents and is geared towards adolescents 11-15 years of age. The MCH staff will work with the Boys and Girls Club to recruit interested teens and parents to participate.

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	2007	2008	2009	2010	2011
Annual Performance Objective	32	45	45	45	47
Annual Indicator	44.1	60.7	43.0	62.4	64.2
Numerator	631	639	459	654	661
Denominator	1430	1053	1067	1048	1030
Data Source		MCH School Outreach Data	MCH School Outreach	MCH School Outreach Data	MCH School Outreach
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?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	65	66	67	68	70

a. Last Year's Accomplishments

1. Fissure Sealant Coverage

The MCH School Outreach (MCHSO) achieved an annual indicator of 64.2 for this performance measure. The target level for receiving fissure sealant continues to be third grade students,

territorial-wide. A total number of 704 third grade students were screened in the school year 2010-2011. Out of 704 students screened, 661 students (94% screened) had at least one permanent molar sealed.

The Department of Education enrolled 1009 third grade students, and an additional 21 students were added from a private school. This resulted with a denominator of 1030. The MCH dental team served 68.3% of these third grade students, island-wide. Each student screened also received a cleaning, topical fluoride (varnish) treatment, oral hygiene instructions and a report card to take home. Screening usually occurs on the first day of school visit.

The MCH team continued to join forces with the SCHIP Dental Team (SCHIPD), and visited the heavily populated schools together. SCHIPD targeted second and fifth grade students. Because the SCHIPD was also providing dental restorations and extractions beside fissure sealant, some of the third grade students who were in need of emergency care were referred to them on site.

Students who were unable to receive fissure sealant were due to various reasons:

1. Permanent molars are carious or have existing dental fillings.
2. Molars are missing because they were extracted previously due to dental caries.
3. Students absent when called for fissure sealant.

2. Caries Experience

The third grade age group ranges from 7 to 9 years of age and has a mixed dentition of both deciduous (baby) and permanent teeth. A total number of 566 (80.4% screened) students had at least one tooth (mixed dentition) affected by dental caries. Of those affected, 61.8% had at least one baby tooth decay, and approximately half had decayed (untreated) permanent teeth.

Every child was given a dental report card to let parents and/or caregiver know about their dental status. It also informs them of any need to take their child for further treatment and why. Those who were complaining of toothaches at the time of screening were treated immediately at school (either by simple dental extractions and/or dental restorations) or referred to the nearest dental clinic (root canal treatments and more complicated dental extractions that may need dental x-rays).

3. School Access and Coverage

There are currently 22 public and 10 private schools. MCHSO served 14 public schools (six were together with SDT) and 1 private school. SCHIPD served the rest (8). The number of days the team remained in these schools ranged from 1-3 weeks. Traveling time to schools varied from 30 minutes to an hour, using the MCH dental truck (can seat four people) and the SCHIP van. MCHSO had also provided services to second and fourth grade students in small schools.

4. Dental Health Awareness and Public Promotion

I. Social Services Day Care Health Awareness Activities

In October 2010, the MCH staff including the dental team was invited by the Department of Human and Social Services (DHSS) to take part in promoting health awareness in their annual iCare activities. DHSS and its partners were able to hold Halloween costume contests, provide drinks and snacks as well as displaying educational booths, disseminating educational handouts and incentives for clients and families of Day Care Centers island-wide. Approximately 450 children and their families attended this one day activity. Tooth brushing demonstrations, toothbrushes and dental coloring books were provided at the MCH booth beside their regular maternal and child health promotions.

II. Department of Education Wellness Fair

The MCH staff took part in the Wellness Fair held in April 2011. The dental team provided toothbrush demonstrations. Each child was given incentives once they demonstrated the correct method. Incentives included a toothbrush, dental stickers and a coloring book. Nutrition and physical activity games were provided by the MCH health education staff. A total number of 252 were seen at the dental booth.

5. Dental Resources

Dr. Anaise Uso was fortunate to receive two hired dental assistants (MCH Block Grant) to assist her after the Ameri Corps women (volunteers) left the department. These volunteers had assisted her the year before while the MCH program was in the process of hiring. Purchasing of all dental supplies and equipment are funded under the MCH Title V Block Grant

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Dentists worked with the Department of Education to provide preventive dental services to school children on site free of charge.	X			
2. The MCH Dental team is currently revising consent forms to make it easier for parents to give consent for services at the schools, as well as notifying parents and caregivers that this consent covers the child for two years.				X
3. The MCH multimedia campaign includes public service announcements on early and regular dental screenings; and nutrition to promote oral health.		X		
4. THE MCH Dental team continues to promote dental health by distributing educational pamphlets at community outreach activities.		X		
5. The MCH Dental team provides free preventive dental services for all children during Children's Dental Health Month as an annual promotional activity.	X			
6. The MCH Dental team provides oral health presentations and preventive dental services to all elementary and high school Gear Up students during Children's Dental Health Month as an annual promotional activity.	X			
7. The MCH dental team conducted screening of fourth graders for fissure sealant retention.	X			
8.				
9.				
10.				

b. Current Activities

1. Fissure Sealant Coverage

Nineteen public and five private schools were covered in school year 2011-2012. DOE enrolled 1015 third grade students for this year. Private schools visited had a total number of 137 students. This is a total of 1152 third grade students (denominator) targeted this year. MCHSO screened 712 students and 678 (58.9% enrolled) had at least one permanent molar sealed. Two public schools (Coleman and AP) scheduled at the beginning of the school year for visitation cancelled out due to inadequate space. Coleman is one of the heavily populated schools that the team usually visits together with SCHIPD. As a result, more private schools were visited. This explains the increase in the number of students with sealants but the percentage for this

measure decreased because the denominator has increased.

2. Dental Hygiene Education and Promotion

- Dental health promotion at high schools, elementary and Early Head Start (ECE), and wellness fairs. A total of 547 children received dental health tips.

3. Supplementary funding.

- The MCH program together with the LBJ Dental services applied for a HRSA grant on April 4, 2012, known as the American Samoa Oral Health Workforce Development Initiative, aiming to increase access to dental outreach services. Announcement for awards will be made prior to September 2.

4. Staffing

At the end of April, 2012, the MCHSO was down to one dental assistant. Human Resources is currently working on hiring a replacement.

c. Plan for the Coming Year

1. MCH School Outreach Preventive Services

Dr. Uso will continue to screen and provide preventive dental services to third grade children in Elementary Schools, and CSHCN in Elementary and High Schools. Second and fourth grade students will also be serviced in small populated schools. The following are activities planned for the coming year:

1. By July 31, a schedule for the new school year will be turned in to the Director of DOE for the school year 2012-2013. Copies will also be provided for the elementary division head.

- LBJ and MCH teams will meet to finalize the schedule prior to this date.

2. By July 31, a written report on the oral health status and dental services received by school children in the school year 2011-2012, to the Director of DOE and its principals.

3. By August 31, plans for visiting the schools in the Manua islands will be confirmed.

4. By May, 2013, MCHSO will provide a comprehensive and policy and procedure manual for the Medical Director to approve.

2. Dental Resources

Dr. Uso will continue to request for additional staffing of no more than two dental assistants, preferably one to be a certified dental assistant to complete the MCH dental team. She will also continue to monitor existing dental equipment and supplies and will let the MCH coordinator know early when there is a need for replacement and/or reordering.

3. Strengthening collaborations and partnerships

1. By July 31, MCHSO and SCHPD will meet to share and review annual reports. School schedules will be confirmed.

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	2007	2008	2009	2010	2011
Annual Performance Objective	4	4	3	1	1
Annual Indicator	3.8	0.0	4.5	5.1	5.1
Numerator	1	0	1	1	1
Denominator	26444	25783	22212	19425	19425
Data Source		Vital Statistics	Death Data from HISO-ASHA	Vital Statistics	DOH - HIS
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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	3	3	2	2	1

Notes - 2011

Denominator based on the American Samoa 2010 Census.

Notes - 2010

Vital Statistics is the Data Source. This was a pedestrian who died due to a motor vehicle. The denominator has been updated from the 2010 Census.

Notes - 2009

The Death Data reported by HISO ASHA has one case categorised under this age group.

a. Last Year's Accomplishments

The Health Education staff continues to provide fitting of car seats for parents of newborns through the nursery, and to Well Baby Clinic clients. The car seats are provided through a partnership with the Office of Highways Safety. Both infant and toddler seats are offered. Many of the parents who request the car seats are moms who have been previously seen at Prenatal Clinic and received education on child safety restraints, then were followed at the hospital post-delivery. The health educators fit the baby for the car seat, as well as give instructions on the correct installation in the vehicle and the correct fit for the baby as they grow. Parents are also aware that when the baby grows beyond the capacity of the newborn seat they can return for the toddler seat, which can also be done in conjunction with their Well Child Visit.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Recertification of MCH staff as Car Seat Installers Technicians.				X
2. "Safety while travelling" inserted in the Well Baby Health education Manual for MCH staff to use at WBCs, prenatal clinics, maternity ward and community outreach activities.		X		
3. MCH Staff collaborated with OHS to promote the "Click it or ticket campaign" at clinics and during community outreach activities such as health fairs.		X		

4. Install car seats for parents and caregivers of infants and young children.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Program continues to address child safety through the Well Baby Clinic Health education modules. This is also reinforced by offering fitting and installation of free car seats. The MCH staff will continue to partner with the Office of Highway Safety, EMSC, and the Child Care Agency to offer this service to children and their families. Current activities include:

- The MCH certified technician and pertinent partners (OHS, EMSC, DHSS) continue to meet for any car installment fair or organized venue for families, parents who wish to have new car seats installed.
- The MCH Staff who are certified technicians continue to provide counseling, education on the proper method of installing car seats using seat belts, tethers, and latches to prevent children from major harm in vehicle accidents.
- The health promotion vehicle safety topic for children under five years old is the constant message at Well Baby Clinics, Prenatal Clinics and other outreach venues.

c. Plan for the Coming Year

The MCH staff will continue to partner and coordinate with the Office of Highway Safety to address child safety on and near roadways. Plans for next year include a request for re-certification of the current staff, and training course for new staff for certification. The new training efforts will be focused on the Home Visiting and health center staff, to ensure car seats are available at all Well Baby locations as well as to clients of the Home Visiting Program.

The MCH staff will also partner with the Office of Highway Safety in the development of a safety curriculum geared towards schools. Pedestrian safety and safe school zones will be addressed, as well as occupant protection for older children. It has been noted in the 2011 Youth Risk Behavior Survey that adolescents report rarely wearing a seat belt when riding in a vehicle. Public education efforts on this topic will be more focused on the teen population. Incentive programs will also be offered to reinforce education efforts.

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	2007	2008	2009	2010	2011
Annual Performance Objective	36	36	37	37	48
Annual Indicator		45.0	19.4	47.4	56.6
Numerator		605	42	405	172
Denominator		1345	216	855	304
Data Source		Well Baby	Leone & Amouli Well	Leone, Amouli,	Leone & Amouli clinic

	clinic Data	Baby Clinic Data	Tafuna Clinics	
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
	2012	2013	2014	2015
Annual Performance Objective	57	57	58	59
				2016
				60

Notes - 2011

Data reported is from the Well Baby Clinics of Leone and Amouli.

Notes - 2010

Data reported are from the Well Baby Clinics of Leone and Amouli.

Notes - 2009

Data reported for this measure is a sample survey of mothers who access services at the Leone (western district) and Amouli (eastern district) clinics but does not include the two larger clinics in the central areas.

a. Last Year's Accomplishments

The health education staff continues to address breastfeeding through group education sessions during the prenatal period, and individual sessions post partum at the maternity ward. Written health education materials were given out for moms who showed interest in breastfeeding. Topics of the materials included "How breastfeeding works", "How to start a feeding", and "Positioning". Handouts were given to offer information that mothers could take home with them for reference.

Outreach activities targeting breastfeeding continue in the community through media campaigns, health and wellness fairs, and partnering with other agencies to provide outreach on a multi-sectoral approach. The Health education staff partners with the WIC program in offering breastfeeding and nutrition education, as well as the Office of Youth and Women's Affairs to offer coordinated community outreach, and the community health centers to provide health education to both Prenatal and Well Baby Clinic clientele.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH staff celebrated National Breastfeeding week by launching a multimedia campaign.		X		
2. Women are educated in the benefits and proper techniques of breastfeeding in prenatal and OBGYN clinics and on the maternity ward following delivery.		X		
3. An individual and group health education presentations are conducted on the importance of breastfeeding. These are conducted by the MCH team.		X		
4. The MCH team developed educational pamphlets and			X	

materials that will be distributed at community outreach activities.				
5. The MCH team continues to work closely with all stakeholders to find ways to address the need in breastfeeding and increase rates of breastfeeding.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH staff has been working on a project from CDC, the Communities Putting Prevention to Work program to promote breastfeeding as a strategy to combat obesity. Through this effort, the governor re-authorized an Executive Order that entitles mothers who are exclusively breastfeeding to two hours paid leave time for the nursing of their newborns.

Along with the Executive Order, an education campaign has been planned and is starting with the Departments of Health, Human Resources, and Human and Social Services. The Executive Order covers all government employees, and the education sessions planned will target 10 government agencies within the next 12 months.

The MCH staff will continue to work with the Breastfeeding Policy work group to promote the use of executive order to provide much needed support of breastfeeding mothers in the work place. The Communities Putting Prevention to Work project has ended but this effort will continue.

c. Plan for the Coming Year

The health education efforts for breastfeeding will continue in the clinic and community based settings. Additionally, focus groups that were planned for 2012 will be implemented to find out what mothers would find most helpful to enable them to successfully initiate and continue breastfeeding, and what education methods would be most effective.

Efforts to promote the executive order for breastfeeding will continue in 2013. Ten worksites will be targeted for education sessions on 1) Availability of leave time for breastfeeding moms 2) benefits to both employers and employees to support breastfeeding moms 3) how to implement and monitor this policy successfully. A larger promotion of this policy is planned for World Breastfeeding Week in August.

Community outreach efforts will continue, as well as a renewed public awareness campaign on the benefits of breastfeeding and what individuals, families, and employers can do to support breastfeeding.

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	2007	2008	2009	2010	2011
Annual Performance Objective	0	0	30	91	92
Annual Indicator	0.0	0.0	91.2	88.3	91.0
Numerator	0	0	1241	1129	1171
Denominator	1291	1338	1361	1279	1287

Data Source		No Data source	Part C & HISO-ASHA	Part C & HISO-ASHA	EHDI & DOH-HIS
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
	2012	2013	2014	2015	2016
Annual Performance Objective	92	93	93	94	95

Notes - 2011

This numerator is based on the 2011 EHDI data, and the denominator was reported by the DOH - HIS.

Notes - 2010

The Early Hearing and Detection Intervention Program (EHDI) reported that they had conducted hearing screenings for 88.3% of all newborns in 2010. Part C reported that 77% of those screened passed the test. Those who did not pass the screening (23%) were reappointed for additional screenings (and possible audiological evaluation) and are then referred to the American Samoa Early Intervention Program (ASEIP) for early intervention services. Both EHDI and ASEIP are under Part C. Screenings are extended to toddlers who did not receive screening prior to discharge or were born out of the country.

Notes - 2009

This data was reported by Part C, Helping Hands Early Intervention. Their program staff carries out newborn hearing screening at the LBJ Medical Center's nursery room prior to discharge.

a. Last Year's Accomplishments

The Helping Babies Hear Program has entered its third year of screening services and continues to strive for 100% of all newborns screened. The screening is done by the Helping Babies Hear staff, rather than the nursery staff and because the staff is not on duty 24 hours a day sometimes babies can be discharged before they were screened.

Helping Babies Hear has been working to address the issues that lead to a missed screen, including reaching out to families for screening even after hospital discharge. In 2011 additional staffing was hired and trained to enable increased screening efforts.

The audiology team from the University of Hawaii that has been working with the Helping Hands Program has continued to visit American Samoa during 2011. Babies who are referred after the initial screening are then assessed by the team. The team is also able to assess older babies and toddlers who are suspected to be hard of hearing or deaf. Staff of the Helping Babies Hear also receive training during these visits, and continue to become more proficient at the screening and referral process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn hearing screening activities continued this year by				

Part C.				
2. Audiology and other therapeutic services continued to be offered through the Helping Hands Program.				
3. The MCH staff continued to partner with Helping Babies Hear to ensure that newborns are screened and receive appropriate follow up.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The screening coverage continues to improve as the program processes and staff becomes more proficient. Currently there is no dedicated space for screening in the nursery, and that remains a challenge. The nursery is in a very tight space, enclosed by ICU, the operating and delivery room so space is very hard to find. The Helping Babies Hear and Nursery staff continue to conduct screening despite this challenge.

The Helping Babies Hear staff continues to work closely with the hospital Pediatrics department as well as the nursing staff in the Nursery to ensure timely screening of all healthy newborns before discharge. If for some reason a baby is discharged before they were screened the staff works closely with Helping Hands and health center staff to locate the babies family for screening. There are only a few situations where this happens, and the goal remains to screen 100% of all newborns.

c. Plan for the Coming Year

All newborn hearing screening activities will continue in the coming year. Audiology and other therapeutic services will also continue to be offered through the Helping Hands Program. The MCH staff will continue to partner with Helping Babies Hear to ensure that newborns are screened and receive appropriate follow up. For those babies who were discharged before being screened every effort will be made to find them and offer screening within a timely manner. These cases will continue to be coordinated with the health centers to ensure timely and appropriate screening for all newborns.

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	2007	2008	2009	2010	2011
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	26444	26863	26863	25721	25721
Data Source		Census Estimates	Census Estimates	2010 Census	2010 Census
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over			Yes	Yes	Yes

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?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011

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

Notes - 2010

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 healthcare are the administrative fees charged at the hospital.

Notes - 2009

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 healthcare are the administrative fees charged at the hospital.

a. Last Year's Accomplishments

Health care system in American Samoa is very unique, and does not operate on an insurance based system. Therefore this measure does not hold the same significance in American Samoa as it does elsewhere.

While American Samoa law mandates that all residents have access to medical services and cannot be charged for medical services per se, the service providers have instituted a facility usage fee in order to generate revenue for operational costs. This fee is minimal when compared with the cost of service, but sometimes burdensome to families who are very low income. However, no one is denied service based on payment. Services are available to everyone and subsidized by Medicaid as it is implemented in American Samoa.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Program continues to be involved in planning around the health insurance situation in the Territory to ensure that all MCH clients are served by participating in Medicaid plans.				
2.				
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Currently the Department of Health has submitted a request to be included in the amendment of the Medicaid state plan. The Medicaid office is under the governor's office and plans for the amendment have not yet been made clear. The Department of Health leadership will continue to monitor this situation and communicate closely with the governor's office.

c. Plan for the Coming Year

MCH Program continues to be involved in planning around the health insurance situation in the Territory. The MCH Coordinator continues to work closely with the Department of Health administration on this issue for all services for children, to include services for children and youth with special health care needs.

The Department of Health also has some infrastructural improvements to make in order to participate in Medicaid. The Public Health Infrastructure Improvement program plan will address meeting these changes. It is anticipated these improvements will be made in conjunction with the amendment to the Medicaid state plan. The Department of Health leadership will closely monitor this process to ensure services for children are provided with minimum disruption to the families.

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	2007	2008	2009	2010	2011
Annual Performance Objective	50	14	14	33	33
Annual Indicator	14.0	14.3	34.1	36.5	32.7
Numerator	1230	1053	1429	1461	1097
Denominator	8791	7358	4185	4005	3359
Data Source		Well Baby database	ASWIC	ASWIC	ASWIC
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?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	32	31	30	29	28

Notes - 2011

The indicator decreased from 36.5 to 32.7.

Notes - 2010

This indicator is increasing yearly and have been declared by the Department of Health and key stakeholders as a health concern, not only in the children population but the adult population as well.

Notes - 2009

This data was reported by American Samoa's WIC Program.

a. Last Year's Accomplishments

The data reported for 2011 reflects a slight decline in the percentage of children enrolled in WIC who are above the 85th percentile. It is anticipated that when WIC begins to use the WHO standards for child growth charts the data will begin to move in a pronounced upwards trend.

Efforts to address childhood obesity include continuing education on nutrition for infants and young children, as well as the emphasis on breastfeeding. WIC also sponsors mini health fairs at each of the health centers where cooking demonstrations, puppet shows and other activities highlight healthy nutrition and physical activity for the whole family. Cooking demonstrations illustrate how to make healthy meals and snacks using foods featured on the WIC vouchers.

Additionally, collocating WIC in the health centers enables the WIC staff to make referrals to the physician or nutrition staff as needed for their clientele. This also enables services to be coordinated across agencies, in order to serve the community better. The central WIC office is still operational in the town area of the island to serve the central districts, this totals 3 WIC sites.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Individual counseling of parents and caregivers plus health education at the Well Baby Clinics.		X		
2. Well Baby health education modules updated.				X
3. Collaboration with partners (WIC, Health Heroes,W-CAP, ASCC Land Grant, ASCC Gear Up, Boys and Girls Club of American Samoa LBJ,DOE, DOH Diabetes Program) to plan outreach promotional activities, formulate possible policies on service coordination and			X	
4. Documentation and generating reports for the MCH coordinator.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH staff is in the process of reviewing the Well Baby clinic policies and procedures, which will include screening as well as topics for education and anticipatory care. Nutrition, breastfeeding and physical activity remain key topics in all education efforts.

Further, the MCH staff has taken a leadership role in the planning process for non-communicable diseases in the Territory. The epidemic of obesity is becoming more evident in young children and mothers, community wide strategies to address this health issue must be identified. A strategic planning process for the prevention of non-communicable diseases is currently underway and will result in the development of a strategic plan by the end of 2012.

c. Plan for the Coming Year

Efforts to address this measure include continued health education in the health centers and WIC locations. WIC remains a member of the Breastfeeding Policy Work Group responsible for promoting the Breastfeeding Executive order to prevent childhood obesity. The MCH and WIC staff will also continue to coordinate activities for world breastfeeding week, and the mini education fairs at each of the health centers.

WIC has also launched a peer mentoring program for breastfeeding. The MCH education staff will work closely with the breastfeeding coordinator from WIC to coordinate breastfeeding education and referral for home follow up by the peer mentors.

The MCH educators will also work closely with WIC staff to recruit families to participate in Body Works classes, focusing on nutrition and physical activity for women, children and their families.

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	2007	2008	2009	2010	2011
Annual Performance Objective	20	10	7	5	1.4
Annual Indicator	3.3	2.5	2.5	1.5	2.2
Numerator	10	8	8	19	28
Denominator	300	314	314	1279	1260
Data Source		PRAMS-like survey	PRAMS-like survey	Prenatal Clinics	Prenatal Clinics
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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	2	2	1.3	1.2	1.2

Notes - 2010

Planning for a PRAMS-like survey to be conducted by November 2011 have been initiated by the MCH staff.

Notes - 2009

No data is available at this time. This data was usually collected from the pregnancy risk assessment survey. But there was no PRAMS-like survey for 2009.

a. Last Year's Accomplishments

Risk behaviors continue to be addressed during health education sessions at the prenatal clinics at the hospital and the health centers. The impact smoking has on the fetus, the mother and family is emphasized with visual aides. Exposure to second hand smoke is also addressed for both mother, infants and children.

The data reported for this is collected from women attending the prenatal clinic at the hospital,

during the third trimester. All prenatal women who access care at the health centers are referred to the hospital prenatal clinic at 36 weeks of gestation. Of all women seen at this clinic, only 28 women reported smoking during their pregnancy.

Smoking cessation services are offered to all women, and referrals to the Tobacco Quit Line are also made. Follow up of these referrals has verified that all women were contacted by the Tobacco program for cessation support.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Educators have been consistent in reminding mothers and families at the Prenatal clinics the effects and risks of smoking during pregnancy.		X		
2. MCH Educators and Nutrition Educators continue to partner with the Tobacco Control and Prevention Program to increase certified Tobacco Cessation staff.		X		
3. The MCH Educator and Nutrition Educators continue to carry out community outreach sessions at scheduled community events with emphasis on the effects of smoking during pregnancy, smoke cessation, second hand smoking and prevention of initiation.			X	
4. Updated knowledge on prenatal care, including the effects of smoking during pregnancy, behavior communication change, updated evidenced based education tips and related staff in services / training will be prearranged for MCH and Nutrition Educators.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH program will continue to partner with the prenatal clinics and the Tobacco Control Program to implement activities to address this measure. Education efforts in the clinics and through multi media will continue. Cessation support is offered to all women who report smoking in the third trimester. This will also be followed up when they bring their infants in for Well Baby visits, as smoking will continue to be a health risk for mother and baby.

c. Plan for the Coming Year

The MCH Program will continue with all current efforts to prevent smoking during pregnancy through education and public awareness. Additionally, the Pregnancy Risk Assessment-like Survey will be planned and revised for implementation in 2013. Due to lack of staffing for this past year, the survey was not implemented. Recruitment and hiring of a third health educator has been processed and it is anticipated will be hired by the first quarter of 2013.

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	2007	2008	2009	2010	2011
Annual Performance Objective	40	39	15	0	0
Annual Indicator	0.0	0.0	0.0	0.0	31.8
Numerator	0	0	0	0	2
Denominator	5320	6317	5223	6296	6296
Data Source		Vital Statistics	Vital Statistics & 2000 Census	Vital Statistics & 2010 Census	Vital Statistics & 2010 Census
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.			Yes	Yes	
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	1	1	0	0	0

Notes - 2011

Denominator has been updated to the 2010 Census.

Notes - 2010

Vital Statistics had reported zero number of suicides in 2010.

Notes - 2009

There have been no data reported on this performance measure from Vital statistics.

a. Last Year's Accomplishments

Summer time is always a busy time for outreach activities. The MCH Program is always invited to present at summer camps, workshops, and gatherings by different groups in the community. In the FY 2011 the MCH educators worked with teens through the Boys and Girls Club of American Samoa/Taitaitama, Gear Up students and Youth at local churches (Fagatogo Methodist Youth and Full Gospel Church, Voice of Christ, Miracle Temple in Malaeloa). The show of support for the youth was through self-esteem sessions in groups and individual counseling.

Outreach activities for youth always combine topical discussions coupled with fun activities. The activities presented at community events usually focus on adolescent behavioral health and are followed by an activity, such as basketball games, volleyball, zumba exercise, dancing to music and other outdoor field games (relay racing around cones). These activities have proven to help teens relieve some of the pressure and/or melancholy feelings they experience. All events are followed by an evaluation and teens have always rated these activities very positively and indicate they would do it again when offered.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH staff continue to partner with the Teen Suicide				X

Prevention coalition to promote all efforts and activities.				
2. The MCH Team continue to partner with other agencies and programs (Youth and Women, DHSS, Domestic Violence Prevention, DPS etc.)which provide services to teens to promote self-esteem, and address issues surrounding teen suicidee.g. DHSS.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current activities for this measure focus on the opening of the Boys and Girls Club in August. Any further activities planned for teens will be coordinated through the Boys and Girls Club, as one of the key MCH partners. Plans are still in the process as the focus is on opening the club house and enrollment of participants. It is anticipated that by the end of the year, more detailed plans will be in place for future activities.

The MCH Program staff were trained as facilitators for the Life Skills curriculum for teens. This curriculum focuses on improving communication skills, decision making, coping with anxiety and anger, and social skills for teens. Two of the health educators have been certified as facilitators for Life Skills. This will be coupled with the Body Works classes, that focus on healthy lifestyles for teens and their families. The MCH along with several other Department of Health staff are trained facilitators for that curriculum as well.

c. Plan for the Coming Year

Adolescent health issues will be addressed in partnership with the Boys and Girls club. Activities have been suspended during the summer. The club is working on opening a new club house, which will be completed and opened August 1, 2012. Upon opening of the new club house, partners such as MCH will then be involved in a planning process to provide programs for the participants. MCH and the Boys and Girls Club remain partners, and will continue to collaborate in 2013.

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	2007	2008	2009	2010	2011
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	1291	1338	1361	1279	1289
Data Source		Vital statistics	HISO-ASHA	HISO-ASHA	DOH - HIS
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					

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
	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011

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

Notes - 2010

NA - No high-risk newborn facility in American Samoa but 5 very low birth weight infants were delivered in the main hospital's, labour and delivery. Vital Statistics recently turned in data that showed that over 50% of IMR was due to infants ages 28 weeks or less. Vital Statistics also reported that the second most common cause of infant deaths was related to premature births. The most common cause was due to heart problems.

Notes - 2009

American Samoa does not have a high risk birthing facility.

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. Not applicable.				
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

Plans to increase early initiation of prenatal care will include continued promotion of the financial incentive program for mothers. The increase in early initiation of care is attributed to mothers who are coming in early for services to enroll in the financial incentive package, where a woman will have a discounted inpatient visit for delivery if they initiate care in the first trimester.

Efforts to promote the program will be carried out through media, mainly on the local public

television channel. This will also be promoted at all outreach activities.

The MCH staff will continue to partner with other service agencies such as WIC to encourage women to access prenatal care early. Prenatal services will continue to be offered at the community health centers during regular clinic hours, with extended clinic hours on certain days of the week. The MCH nurse practitioners and health education staff will continue to offer prenatal visits at no cost to the patients as long as they enroll early. After the third trimester, a facility usage fee will be charged for all labs required to be done at the main laboratory at the hospital as well as inpatient administrative fees.

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	2007	2008	2009	2010	2011
Annual Performance Objective	14	14	19	22	42
Annual Indicator	22.1	19.5	23.1	41.0	45.4
Numerator	96	225	155	332	431
Denominator	435	1153	670	809	950
Data Source		MCH Database	MCH Kotelchuck Index Data	MCH Kotelchuck Index Data	MCH Kotelchuck
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
	2012	2013	2014	2015	2016
Annual Performance Objective	46	47	48	49	50

Notes - 2011

Data Source: The denominator is a total number of postpartum and newborn cards collected by MCH staff.

Notes - 2010

American Samoa does not collect birth data on the current birth certificate. Therefore those data are not available from vital statistics. The data reported for this measure is a sampling of post partum records with completed data, meaning all data field required to calculate the KI was documented.

Notes - 2009

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.

a. Last Year's Accomplishments

The data for this measure does show an increase in the number of women who are accessing prenatal care services early in pregnancy. However, the attainment is still below recommended

levels and there remains room for big improvements. Data collection is slowly improving for this measure as well. The American Samoa Certificate of Live Births has not been amended to collect all birth related data, making the data collection efforts for this measure tedious and time consuming.

The increase in this performance measure is attributed to the financial incentive program instituted by the hospital. The hospital offers discounted inpatient fees for all women who access prenatal care in the first trimester, and many women say it was the reason they came in early.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health Education at Prenatal clinics.				
2. The MCH Staff continue to partner with WIC and the health centers to promote and encourage women to access prenatal care in the first trimester.				
3. The MCH Staff collected newborn and postpartum cards and recorded all information so adequate data is collected and analyzed.				
4. Issues and health concerns during pregnancy continue to be addressed in public service announcements and on the public television shows sponsored by the Department of Health.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Staff will continue to partner with WIC and the health centers to promote and encourage women to access prenatal care in the first trimester. Issues and health concerns during pregnancy will continue to be addressed in public service announcements and on the public television shows sponsored by the Department of Health.

It is anticipated that the Maternal, Infant, and Early Childhood Home Visiting program will begin implementation of services in October 2012. Prenatal care will also be addressed through home visiting and the MCH staff will continue to work with the home visitors to ensure all required services are provided for enrollees, including pregnant women and those of child bearing age who can become pregnant again.

c. Plan for the Coming Year

Plans to increase early initiation of prenatal care will include continued promotion of the financial incentive program for mothers. The increase in early initiation of care is attributed to mothers who are coming in early for services to enroll in the financial incentive package, where a woman will have a discounted inpatient visit for delivery if they initiate care in the first trimester.

Efforts to promote the program will be carried out through media, mainly on the local public television channel. This will also be promoted at all outreach activities.

The MCH staff will continue to partner with other service agencies such as WIC to encourage women to access prenatal care early. Prenatal services will continue to be offered at the community health centers during regular clinic hours, with extended clinic hours on certain days

of the week. The MCH nurse practitioners and health education staff will continue to offer prenatal visits at no cost to the patients as long as they enroll early. After the third trimester, a facility usage fee will be charged for all labs required to be done at the main laboratory at the hospital as well as inpatient administrative fees.

D. State Performance Measures

State Performance Measure 1: *Percent of 15 month old children with completed immunizations.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					86
Annual Indicator				85.6	81.9
Numerator				666	1346
Denominator				778	1643
Data Source				Immunization Program	IP
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	83	84	85	86	87

a. Last Year's Accomplishments

In the past few years the Immunization Program has focused a considerable amount of resources into the assessment of the immunization coverage of early childhood age groups. A Territorial island wide household survey was conducted and the coverage rate for 19-35 month olds was 75%. A manual data collection effort was done of all clinic records and the coverage rate of the same age group was 69%.

Although it was noted that the coverage rate for 2 year olds was low, it was also noted that the drop off occurred at 15 months of age. After the 15 month shot, parents were not bringing their toddlers back in until they were ready for preschool or day care. 15 month olds were then targeted as an age group of special significance and have been targeted in outreach activities.

These rates were consistently low and are the reason immunization coverage was identified as one of the priority needs for MCH. Plans to increase coverage were made to the Centers for Disease Control and Prevention. Request for additional funding and resources was approved and resulted in a multi-faceted approach for community outreach and awareness campaigns. The low coverage rates were partially attributed to the high volume traffic in the two larger clinics, and low level of nursing staffing. For this reason new efforts and resources focused on services that were above and beyond what has been offered in the clinics.

Outreach activities included extended clinic hours to offer services later into the evening, providing services from a mobile unit at various locations island wide such as sporting and community events, and at popular shopping and eating venues. A mass media campaign was also launched to include radio, television newspaper and billboards.

These efforts have resulted in a significant increase in the coverage rate reported for 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Along with direct services in the health centers to provide vaccinations, the MCH and Immunization Programs continue to work on development of electronic record systems to ensure availability and portability of health records.				
2. Multimedia campaign.				
3. Back to school afterhour clinics.				
4. Electronic data collection (WebI2) has been installed and functioning.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program continues normal program activities which include partnerships with the Head Start Program, the Child Care program and various community organizations. Assessment of records is conducted at child care centers, head start and at school registration. Children who are delinquent are referred to the local health centers to receive the age recommended immunizations.

Prior to school starting in the fall, the Immunization Program launches a Back to School promotion to encourage parents to bring their children in for their vaccinations before school registration.

The Immunization program also partners with the Child Care Program to offer education to child care providers on completion of age appropriate immunizations for the child care eligible children. Additionally, the program also partners with WIC to ensure that eligibility workers are able to read the immunization cards and make the appropriate referrals to the health centers for immunizations.

Other program activities include:

1. Multi- media campaign.
2. Documenting and Generating reports from data in the Web-based registry.
3. Community Outreach during health fairs and stations at public parks, giving out flu shots and promoting and updating families of infants and children about their immunization shots.
4. Regular inservices for nurses to keep them up to date with appropriate policies and procedures.

c. Plan for the Coming Year

Along with direct services in the health centers to provide vaccinations, the MCH and Immunization Programs continue to work on development of electronic record systems to ensure availability and portability of health records. The efforts to work on the electronic records will continue in 2013.

Also in the coming year, the program has been awarded funds to purchase the mobile unit that was previously on lease. This will ensure that outreach activities will continue, and efforts to reach a higher coverage rate continue.

Immunization coverage remains a priority for MCH and the Maternal, Infant and Early Childhood Home Visiting Program. These programs will continue to partner with the Immunization Program to ensure complete coverage for all enrollees of the Home Visiting Program in 2013.

State Performance Measure 2: *Percent of pregnant women who receive adequate prenatal care based on the Kotelchuck Index.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					39
Annual Indicator				40.2	32.7
Numerator				325	405
Denominator				809	1240
Data Source				Postpartum Records	Postpartum Records
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	34	35	36	37	38

Notes - 2011

A total number of 1240 postpartum cards were recorded by MCH.

a. Last Year's Accomplishments

The data for this measure does show an increase in the number of women who are accessing prenatal care services early in pregnancy. However, the attainment is still below recommended levels and there remains room for big improvements. Data collection is slowly improving for this measure as well. The American Samoa Certificate of Live Births has not been amended to collect all birth related data, making the data collection efforts for this measure tedious and time consuming.

The increase in this performance measure is attributed to the financial incentive program instituted by the hospital. The hospital offers discounted inpatient fees for all women who access prenatal care in the first trimester, and many women say it was the reason they came in early.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The hospital offers discounted inpatient fees for all women who access prenatal care in the first trimester, and many women say it was the reason they came in early.				
2. Better data collection with more postpartum and newborn cards collected, documented.				
3. Multimedia campaign continues.				
4. The MCH Staff will continue to partner with WIC and the health centers to promote and encourage women to access prenatal care in the first trimester.				
5.				
6.				
7.				
8.				
9.				

10.				
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b. Current Activities

The MCH Staff will continue to partner with WIC and the health centers to promote and encourage women to access prenatal care in the first trimester. Issues and health concerns during pregnancy will continue to be addressed in public service announcements and on the public television shows sponsored by the Department of Health.

It is anticipated that the Maternal, Infant, and Early Childhood Home Visiting program will begin implementation of services in October 2012. Prenatal care will also be addressed through home visiting and the MCH staff will continue to work with the home visitors to ensure all required services are provided for enrollees, including pregnant women and those of child bearing age who can become pregnant again.

c. Plan for the Coming Year

Plans to increase early initiation of prenatal care will include continued promotion of the financial incentive program for mothers. The increase in early initiation of care is attributed to mothers who are coming in early for services to enroll in the financial incentive package, where a woman will have a discounted inpatient visit for delivery if they initiate care in the first trimester.

Efforts to promote the program will be carried out through media, mainly on the local public television channel. This will also be promoted at all outreach activities.

The MCH staff will continue to partner with other service agencies such as WIC to encourage women to access prenatal care early. Prenatal services will continue to be offered at the community health centers during regular clinic hours, with extended clinic hours on certain days of the week. The MCH nurse practitioners and health education staff will continue to offer prenatal visits at no cost to the patients as long as they enroll early. After the third trimester, a facility usage fee will be charged for all labs required to be done at the main laboratory at the hospital as well as inpatient administrative fees.

State Performance Measure 3: Percent of 1 year old children attending well baby clinics who receive a package of oral hygiene services (caregiver education, fluoride varnishes, 1 toothbrush/washcloth, sticker)

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					41
Annual Indicator				41.1	23.8
Numerator				526	306
Denominator				1279	1287
Data Source				Well Baby Clinics	Leone & Amouli WCC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	24	25	26	27	28

Notes - 2010

Data was collected and it was concluded that all Well Baby Clinics provided the services except for the Central Clinic. Policies and training will be implemented so that all clinics provide the service and in a more consistent manner.

a. Last Year's Accomplishments

Children seen by the nurse practitioner, Mrs. Tele Hill, at Amouli clinic are provided this incentive as well as all CSHCN clients. The MCH clinician, Dr. Olita Laititi, who used to provide this for Tafuna WBC has moved to the Hospital and because of short staff this service has not been provided anywhere else beside Amouli.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nurse practitioner provides incentive and fluoride varnish at Amouli Health Center (WBC) as well as for all CHCSN clients.				
2. WBC policies have been formulated and is pending review and approval by the DOH Medical Director.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Mrs. Tele Hill continues to provide this services at Amouli clinic and for all CSHCN clients that she sees. A Policy has been formulated and inserted in the MCH WBC "Policy and Procedure" Manual. It is currently awaiting review by WBC physicians and clinicians.

c. Plan for the Coming Year

1. Continue providing this service at Amouli clinic and to all CSHCN clients.
2. Once the WBC clinicians complete reviewing the policy for this service, MCH will take it to the Medical Director for approval. This will ensure that this service can be provided by either a clinician, nurse, CNA or Health Educator.
3. MCH will continue to order and disseminate all supplies needed at each clinics.

State Performance Measure 4: *Percent of 2-5 year old children in well baby clinics not receiving WIC who have a BMI equal to or greater than 85%.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					34
Annual Indicator				34.4	40.4
Numerator				32	21
Denominator				93	52
Data Source				Well Child Clinics	Leone & Amouli WCC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	39	38	37	36	35

a. Last Year's Accomplishments

This measure was selected to ensure that all children 2-5 years were given the same attention, not just children who were already eligible for WIC services. It was also chosen to look at difference in children who were not participating in WIC.

Efforts to address childhood obesity include continuing education on nutrition for infants and young children, as well as the emphasis on breastfeeding. WIC also sponsors mini health fairs at each of the health centers where cooking demonstrations, puppet shows and other activities highlight healthy nutrition and physical activity for the whole family. Cooking demonstrations illustrate how to make healthy meals and snacks using foods featured on the WIC vouchers. All activities are also open to non-WIC clients to attend for nutritional promotions.

Additionally, collocating WIC in the health centers enables the WIC staff to make referrals to the physician or nutrition staff as needed for their clientele. This also enables services to be coordinated across agencies, in order to serve the community better. The central WIC office is still operational in the town area of the island to serve the central districts, this totals 3 WIC sites.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Staff providing individual counselling and group health education at the WBC in the Health Centers.				
2. Multimedia campaign continues.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH staff is in the process of reviewing the Well Baby clinic policies and procedures, which will include screening as well as topics for education and anticipatory care. Nutrition, breastfeeding and physical activity remain key topics in all education efforts.

Further, the MCH staff has taken a leadership role in the planning process for non-communicable diseases in the Territory. The epidemic of obesity is becoming more evident in young children and mothers, community wide strategies to address this health issue must be identified. A strategic planning process for the prevention of non-communicable diseases is currently underway and will result in the development of a strategic plan by the end of 2012.

c. Plan for the Coming Year

Efforts to address this measure include continued health education in the health centers for both WIC and non-WIC clients and in WIC locations. WIC remains a member of the Breastfeeding Policy Work Group responsible for promoting the Breastfeeding Executive order to prevent childhood obesity. The MCH and WIC staff will also continue to coordinate activities for world breastfeeding week, and the mini education fairs at each of the health centers to also include non-WIC clients.

State Performance Measure 5: *Percent of 1 year old children attending well baby clinic who received a Hgb screening.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					36
Annual Indicator				36.4	16.0
Numerator				466	86
Denominator				1279	536
Data Source				Well Child Clinics	Leone & Amouli WCC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	17	18	19	20	20

Notes - 2010

All clinics provide this screening except for the Central Clinic. This clinic's supervisor claimed that it does not have the resources to provide this service.

a. Last Year's Accomplishments

MCH staff continues to reinforce adequate nutrition to parents and caregivers at the Well Baby Clinic. Nutrition tips that include foods that are high in iron, balanced diet with healthy portions, exercise and plenty of water.

When a child is screened and has a hemoglobin measure below 11g, the child is counseled by the health educator, if there be a need to advise the mother to purchase iron supplements then that advice is given. Nutrition counseling and follow up Hgb, rechecks are scheduled.

Nutrition counseling and Foods rich in Iron are displayed at the Wellness Health Fair, Nutrition Health Heroes Health Fair, Booth displayed during the Armed forces Day.

Television and Radio programs have aired Nutrition promotions.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Individual counselling and group educations at the WBC by MCH staff.				
2. Partner with WIC to continue providing multimedia campaign.				
3. Partner with Land Grant to be part of the advisory committee to their Children's Health Living Project.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Educators have been visiting the Leone and Amouli Well Baby clinics, giving health presentations on Healthy meal planning, First foods for baby at 6 months emphasizing iron rich foods. Focus during the Prenatal period on the diet of the pregnant mother, on foods also rich in iron, taking her iron pills pre and post natally.

The Well Baby Modules are in motion to be revised to include indebt information about Iron deficiency anemia.

Radio and TV spots have included health talks on nutrition with iron rich foods promotion.

Information from the Body Works material has been used as a tool to present health nutrition talks.

c. Plan for the Coming Year

The MCH Health Educators will continue to go out to the Well Baby Health Clinic with emphasis to reschedule staff allocations to visit the larger populated clinics.

The MCH staff will continue to revise and pilot the Well Baby Module and prepare if for launching.

The MCH Staff will continue to attend community outreaches and promote healthy eating and nutrition to the family as a whole.

The Body Works trainers will work as a team and give Body Works sessions to community/church organizations who request this training.

The MCH staff will prepare material for nutrition promotion on the radio and television.

Data will be collected in a timely and efficient manner and reported to the MCH Coordinator on a monthly and quarterly basis.

State Performance Measure 6: *Percent of CSHCN who have annual assessments completed.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					100
Annual Indicator			100.0	100.0	40.5
Numerator			146	151	60
Denominator			146	151	148
Data Source			CSHCN Program	CSHCN Program	CSHCN Program
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	42	43	45	46	47

Notes - 2011

This data is an estimate of CSHCN children who have an annual assessment done by the CSHCN team. Once data is confirmed, it will be finalized.

a. Last Year's Accomplishments

The Children with Special Health Care Needs team (CSHCN) has continued to provide physical examinations to clients in the CSN program. There have been clients who have not had annual assessments due to having relocated off island, or their medical issues have been resolved through medical or surgical treatment. The CSN staff has continued to attend Grand Medical Rounds at the American Samoa Medical Authority Center (LBJ), Pediatric Ward/Nursery/ICU areas. Discharge planning and referrals from these areas if there are special needs are referred to the program.

The CSHCN team has continually worked with the Helping Hands, in particular the Physical Therapist in scheduling / visiting for follow up clients. These visits are coordinated and organized to assist with any medical physical needs of the clients and families.

The CSHCN team has worked throughout the school year with the MCH Dental team. The Department of Education, Special Education (SPED), has worked with the CSHCN in scheduling visitations to High Schools and collaborated home visits.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN team continue proving annual assessments at school and at home.				
2. Partner with the Hospital and Shriners to update clients while clinics are being held.				
3. Continue to partner with Part C, CFIDD, Voc Rehab, SPED and others to identify all aligible clients and ensure they receive annual assessments.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN team continues to assist all clients and their families, providing annual evaluations. A few clients were discharged once they become of age or have resolved their medical issues through various treatments or surgeries.

The CSHCN team has been working closely with the Helping Hands (early intervention) program, carrying out home visits for the CSHCN even on weekends when it is best for the families.

The staff from the Special Education Department (SPED) has also been very instrumental in coordinating home visits for children who have not been able to attend school due to a health issue. Students who have been missing school are visited by the CSHCN team, through coordinating efforts by Special Education and Department of Health staff.

c. Plan for the Coming Year

The CSHCN staff has continued to partner with different service arms of the Department of Health to ensure that services to program enrollees are implemented. The program staff primarily serving the CSHCN clients are the Health educator, MCH Dental Outreach Team and the Helping Hands (early intervention) Team.

Efforts to strengthen coordination and partnership with the Community Health Centers will also be emphasized in the coming year. Better coordination with community based services is needed to improve the service systems for Children, Youth with Special Health Care Needs. The MCH staff will also make efforts to work with the pediatric department at the hospital to coordinate referrals, follow up, meeting recommended services in timely manner, as well as education and awareness activities.

State Performance Measure 7: Number of youth and families who participate in BodyWorks class during the project year.

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					86
Annual Indicator				85.5	85.5
Numerator				165	165
Denominator				193	193
Data Source				Boys and Girls Club	BGC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	86	87	87	88	88

a. Last Year's Accomplishments

MCH staff promoted the BodyWorks project in the community by providing talk shows on radio and local television.

Trained staff kicked off the BodyWorks project in November 2010, and was catered for participants of the afterschool mentoring program of the Boys and Girls Club of American Samoa. This ended in May 2011.

MCH and key stake holders held regular meetings to report on all activities throughout the implementation of the 10 week sessions.

All participants for the BodyWorks session received a certificate of participation. All participants had BMI measurements reading and were recorded for documentation.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with Boys and Girls Club to provide BodyWroks sessions to their members.				
2. Had renew MOU with Boys and Girls club to continue services once their building is ready to be used and is accessible to their members.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

MCH Staff continued to partner with Boys and Girls Club (BGC), Taitaitama Initiative and other stakeholders to plan for the upcoming school year. An MOU was drafted and signed between DOH and the Boys and Girls club to continue providing this service for 2011-2012 school year. MCH staff will ensure that all materials will be ordered in time for the second kick-off of this project with the Boys and Girls Club, most likely the beginning of school year 2011-2012. This will occur once the BGC completes the renovations to its facility. The MCH Program promoted the BodyWorks concept by hosting talk shows on radio and local television. All services were recorded and documented.

c. Plan for the Coming Year

MCH Staff will continue to partner with Boys and Girls Club, Taitaitama Initiative and other stakeholders to plan for the upcoming school year and to implement it.

MCH staff will ensure that all materials needed are at hand for the second kick-off of this project with the Boys and Girls Club.

The MCH Program will continue to work together with existing partners to promote the BodyWorks concept by hosting talk shows on radio and local television.

All services were recorded and documented.

E. Health Status Indicators

/2013/

Data reported for the Health Status Indicators in 2011 remains consistent with previous years. The number of vital events in the Territory that the percentages for most of these indicators remain very low. The exception in 2011 was the rate of non-fatal injuries due to motor vehicle accidents. The big difference in the rate from 2010 to 2011 is attributed to the low number of events reported in 2010.

The MCH Program continues to partner with the Office of Highway Safety to improve data capture and reporting systems for this and all injury indicators, as well as planning and implementation of community prevention activities to reduce traffic related incidents.

//2013//

F. Other Program Activities

Community Needs Assessment for Public Health Emergency Response to the Post-Earthquake and Tsunami on September 29, 2009: The Department of Health (DOH) conducted a community needs

assessment to determine the various needs that DOH and its partners address these needs. It was conducted according to three major areas which were:

1. Basic public health needs with respect food, water, shelter, household goods, sanitation, public utilities, healthcare and infrastructure are accurately projected.
2. Special needs of the population are identified to include vulnerable populations, (i.e. children, the elderly, pregnant women, chronically ill, etc)
3. Special risk factors for further morbidity and mortality are identified, (i.e. use of carbon-monoxide generating equipment, access to clean drinking water, etc.)

With CDC's technical assistance, staff were trained prior to the implementation, documentation and reporting. The community health assessment in public health emergencies (CASPER) was used as the methodological approach, designed to rapidly determine the household-level needs of a disaster-affected community.

The various needs that were identified were:

- 1) Provide a continuing source of potable water, especially for persons dependent on relief agencies for water deliveries.
- 2) Provide immediate appropriate shelter for person with damage to their homes, including provision for temporary measures such as tarpaulins. Prioritize re-settlement in personal residences whenever possible. In cases where displacement is unavoidable, prioritize private residences and host communities over large shelters.
- 3) Provide a short-term feeding program for displaced populations that depend upon shelters for nutrition. Transition to sustainable food distribution as soon as possible during the recovery phase.
- 4) Provide accessible medical care for persons, particularly vulnerable populations such as nursing or pregnant women, the young, elderly and those with chronic health conditions. The current service of community-based clinics in and near affected areas in Leone and Amouli should be fully staffed. Consider community outreach of primary and preventive healthcare services in order to reach isolated populations and decompress the burden on clinics and the hospital.
- 5) Offer mental health services, including outreach services for persons unwilling to travel. Continue to coordinate local mental health services in conjunction with visiting teams.
- 6) Enhance the ability of public health surveillance systems to detect and monitor outbreaks of infectious diseases, including influenza, through ongoing collection and analysis of healthcare visit data.
- 7) Continue to monitor environmental health conditions, in association with the Environmental Protection Agency (EPA) during clean-up and recovery phases. Implement a waste management system for hazardous material disposal. Consider restricted burning in residential areas, to avoid toxic exposures and exacerbation of acute and chronic respiratory disease.
- 8) Engage environmental health authorities in planning and implementing a vector control program to reduce

mosquito breeding sites and inform the public of measures to reduce the risk of mosquito bites.

9) Prevent illnesses from 2009 pandemic H1N1 influenza by implementing a community vaccination program.

10) Continue public education and risk communication through multiple media outlets.

Provide guidance on self-

protective behaviors to include food and water safety, hygiene messages, hazardous materials and carbon-

monoxide exposures and environmental risks such as heat-related illness. Continue health education messaging

related to self-protection and non-medical counter-measures for H1N1 at the personal, family and community levels.

Continue mental health telephone help line services.

11) Promote worker safety during the cleanup and recovery phases to include falls, burns, electrocutions and

equipment-related injuries, (i.e. chainsaws, gas stoves, generators, heavy equipment).

/2013/

In addition to playing a key leadership role in the needs assessment and planning process for NCD's, the MCH

Coordinator has been actively involved in the Maternal, Infant, and Early Childhood Home Visiting Program, and the

Public Health Infrastructure Improvement (PHII) program. Both of these programs are new initiatives, requiring

additional time and effort towards planning, implementation and supervision of staff. New staff has been hired for

the Home Visiting Program and the PHII program, however due to the scope of these programs and impact on the

Department operations and on the community, senior MCH staff remain in leadership roles for both programs.

//2013//

G. Technical Assistance

There is still a need for Data System Development territorial-wide. All partners should be able to enter this system and enter individual data pertaining to their program and services. In 2011, with the assistance of the SSTI grant, the TA contract from American Samoa Medical Authority will assist the department to set up the CPRS system in all health centers.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	498448	498448	497378		495334	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	509523	509523	404180		404180	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	1007971	1007971	901558		899514	
8. Other Federal Funds <i>(Line10, Form 2)</i>	100000	100000	100000		100000	
9. Total <i>(Line11, Form 2)</i>	1107971	1107971	1001558		999514	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	149534	149534	138631		138631	
b. Infants < 1 year old	152857	152857	158437		158437	
c. Children 1 to 22 years old	454947	454947	265279		273234	
d. Children with	149535	149535	258776		258776	

Special Healthcare Needs						
e. Others	51254	51254	56466		45436	
f. Administration	49844	49844	23969		25000	
g. SUBTOTAL	1007971	1007971	901558		899514	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	503986	503986	419224		413776	
II. Enabling Services	151196	151196	130726		130429	
III. Population-Based Services	251992	251992	216374		220382	
IV. Infrastructure Building Services	100797	100797	135234		134927	
V. Federal-State Title V Block Grant Partnership Total	1007971	1007971	901558		899514	

A. Expenditures

Differences in amounts budgeted compared to amounts expended are due to a discrepancy in the amount forecasted for the budget that year. The amount of the working budget awarded at the beginning of the fiscal year was less the amount entered on the budget forms. Therefore the large difference in sums is due to a reporting error in the amount entered in the Budgeted column.

B. Budget

Maintenance of effort is maintained through State in kind match using local investments such as staffing in both administration and direct health services. Staffing to support MCH services include the health center staff: nurses, clerks, health assistants, doctors and other support staff. The Deputy Director of Health serves as the MCH Program Director. She and members of her staff in finance and personnel who provide administrative support are also included in State investment as her salaries are paid through State funding.

Local infrastructure is also a pivotal component of MCH services. All facilities where MCH activities and services are delivered are government owned facilities. This includes the MCH and SSDI Office, and all of the clinics where MCH direct services are provided.

In the 2012 fiscal year, there is an increase in resources budgeted for direct health care services for pregnant women, infants, and children. The needs of these population for direct services has been increasing and the MCH Program make every effort to ensure services are accessible by offering them free of charge. With hard economic times, more and more families have come to depend on services offered by the Department of Health due to cost.

In 2013 fiscal year, there is added staffing in MCH to prenatal care due to the presence of the new physician. She will be servicing Well Baby Clinic clients as well.

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.