State Action Plan Table (American Samoa)						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Increase Access and Awareness to Adequate Prenatal Care.	Increase by at least 10% the number of pregnant women coming in for prenatal care from 1st trimester. Increase by at least 10% the number of pregnant women who came in on 1st trimester and have completed 80% of follow up visits. Reduce smoking by 10% amongst pregnant women.	Create incentives for pregnant women who comes in 1st trimester and completed 80% of follow up visits. Conduct a group of parental care that falls in the same months. Conduct educational group session during prenatal care and offer incentives for maximum participation. Increase community awareness on the effects of smoking during pregnancy. Strengthen partnerships with stakeholders on activities for pregnant women. Promote the use of the “Smoking cessation during pregnancy: A clinicians guide to helping woman quit smoking” tool	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks)	Percent of women with a past year preventive medical visit		

		among health care provider, from the American College of Obstetricians and Gynecologists. Promote self and provider referral to the Tobacco Program QUIT line (1-684-633-7475). Promote use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) among health care providers.	Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

State Action Plan Table (American Samoa)						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Reduce infant mortality rate.	Increase by 5% of women enrolled in prenatal care services sitting in a nutrition and pregnant woman life style session. Increase by 5% Pregnant Women who smokes and quit by third trimester. Reduce the rate of infant mortality by 10%	Provide incentives for women who have attended nutrition and pregnant women lifestyle session conducted by Title V staff. Collaborate with Tobacco Program, Prental Clinics and OBGYN clinics to ensure Clinicians are screening every client for smokers and refer for treatment and / or counselling in order to quit.	Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)		
Increase Breastfeeding babies at 3 months and 6 months of age.	Increase breastfeeding in 3 and 6 month old infants by 10%	Establish / Update a baseline data for this population by the end of FY2016. Continue to increase awareness and promotion in the community, prenatal and well baby clinics.	Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)		

		Provide CME updates on effective breastfeeding initiatives for all staff, providers, including clients and their families. Collaborate with NCD programs to advocate for breastfeeding mothers and increase awareness in health benefits such as reducing childhood obesity.	Preterm-related mortality rate per 100,000 live births			

State Action Plan Table (American Samoa)						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Reduce Childhood Obesity.	Increase by 10% # of children participating in physical activity in all schools. Increase by 10% # of school teachers actually conducting physical activity with class during physical education classes. Increase by 10% # of schools with most PE classes that has the most turnout in #s of individuals actually participating during PE classes.	Conduct physical activity sessions in schools (elementary) to promote the benefits. Incentive for the schools who has the most physically active children.	Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		
Promote evidence based developmental screenings for children 0-5 years of age.	Implement developmental screenings. Train workforce in conducting developmental screenings.		Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool		

State Action Plan Table (American Samoa)						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Increase Immunization Coverage Rates.	Increase immunization coverage rates among adolescents	Collaborate with ASIP and key partners including families and the community to ensure that children get fully immunized prior to entering schools. Promote and disseminate evidence-based information on immunizations for adolescent population. Increase program implementation that uses innovative approaches to increase awareness so families can make informed decisions. The MCH staff will also collaborate with the Department of Health's Medical and Dental Staff (MDS), ASCHC Clinical Director, Executive Director and CHC Quality Improvement Manager	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

		in developing a plan to work with health care providers on making health prevention visits more teen friendly through Primary Health Care Clinics. Also develop a plan to have Well Adolescent Visits mandatory annually. All high school students who play competitive sports are required to get a physical screening prior to playing. This should be mandatory for every adolescent student.	vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			
Prevent adolescents from being bullied or bulling others.	Decrease adolescents who are being bullied or bullying others	Group Counselling and focus group sessions.	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Percent of adolescents, ages 12 through 17, who are bullied or who bully others		

State Action Plan Table (American Samoa)						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve system of care for CYSHCN.	Strengthening workforce specifically for CYSHCN. Increase by 25% the number of children and youth with special health care needs accessing an ongoing, coordinated, and comprehensive care within a medical home.	Conduct TA for health care providers in this specific population. Conduct field days for this population at least twice a year for this type of population. Continuous collaborative efforts with all key partners including family advocates and medical providers are ongoing to assist CYSHCN to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families. These services are family-centered, community-based and culturally competent.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	Percent of children with and without special health care needs having a medical home		

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

State Action Plan Table (American Samoa)						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote oral health in all 6 domains.	By 2020, decrease the rate of Rheumatic Heart Disease through secondary prophylaxis by at least 5%. Increase by 10% # of children being seen by a Dentist for preventive dental care services in the past year. Increase by 10% # of pregnant women who are pregnant to have at least one dental visit during pregnancy.	Establish baseline data for all Objectives by July 2016. Increase oral health awareness for all MCH population during Dental Month Activities, PTA and guardians focus groups, classroom oral health talks, dental PSAs disseminated to all partners to be viewed by their clients in their waiting areas, TV talks and other media avenues. Incentive for pregnant women that are showing up for at least one dental visit. Increase children ages 1 to 17 years of age receiving oral health screening in Dental Homes, Well Baby	Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health	A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year		

		Clinic and schools. Increase children ages 9 to 35 months getting a fluoride varnish at least twice a year. Ensure that there are opportunities for CME for all medical providers focusing on improving oral health in order to improve and increase their service capacity. Improve data collecting and reporting for all dental providers serving children 1-17 years of age. Ensure that all CYSHCN identify and address their dental needs within their medical homes. Ensure that all pregnant women identify their dental homes, get referred and receive a dental screening and cleaning prior to giving birth.				
Reduce Acute Rheumatic Fever and	By 2020, decrease the rate of Rheumatic Heart	Increase awareness in all sectors of the				

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