Maternal and Child Health Services Title V Block Grant

Northern Mariana Islands

FY 2025 Application/ FY 2023 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

Commonwealth Healthcare Corporation
Commonwealth of the Northern Mariana Islands
1178 Hinemlu' St. Garapan, Saipan, MP 96950

CEO-L24-802

June 28, 2024

Michael D. Warren, MD, MPH, FAAP
Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
US Department of Health & Human Services
5600 Fisher Lane Rockville, MD 20857

Subject: **HRSA Announcement No. HRSA-25-001 / Tracking No. 226483**

Dear Dr. Warren,

The Commonwealth of the Northern Mariana Islands' (CNMI) Commonwealth Healthcare Corporation (CHCC) is pleased to submit the FY 2025 Title V Block Grant Application /FY 2023 Annual Report.

The CNMI is grateful for the opportunity to provide a report on the projects and activities that have taken place in the Northern Mariana Islands to improve the health of mothers, children and adolescents, and children with special healthcare needs. The CNMI will continue to use Title V MCH Block Grant funds to provide preventive, primary health care, and population-based services for the women and children in the CNMI.

We thank you for your continued leadership and support of the CNMI MCH Title V Program.

Sincerely,

for

Esther Lizama Muña, PhD, MHA, FACHE
Chief Executive Officer
State/Territorial Health Official

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I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The mission of the CNMI's Title V MCH Program is to promote and improve the health and wellness of women, infants, children - including children with special health care needs (CSHCN) - adolescents, and their families, through the delivery of quality prevention programs and effective partnerships. In the CNMI, Title V supports a spectrum of services, from infrastructure-building services like quality assurance and policy development, to gap-filling of direct health care services for CSHCN.

In the CNMI, the MCH Title V Block Grant award is administered under the Commonwealth Healthcare Corporation, with the Chief Executive Officer as the Authorizing Official and the Public Health Services Director designated as the Project Director. Federal regulations require that at least 30% of the funding must be used for services and programs for children and another 30%, at a minimum, must be used for services and programs for CYSHCN. No more than 10% may be used for administrative costs. Jurisdictions must provide a $3 match for every $4 in federal funds received. Although there are no minimum spending requirements, funding is also to be spent on preventive and primary care services for pregnant women, mothers, and infants up to age one. The CNMI MCH Block Grant funds support state and local program and staff, and are administered by the Maternal, Infant, Child and Adolescent Health (MICAH) unit of the Commonwealth Healthcare Corporation (CHCC).

Every five years, the CHCC conducts a comprehensive, statewide needs assessment to assess the gaps in needs, strengths, and limitations of services available to MCH populations across six domains. The CNMI uses the "Title V Needs Assessment, Planning Implementation, and Monitoring Framework" to guide the needs assessment and program planning process for each five-year cycle, with emphasis placed on engaging stakeholders and community partners. For the 2020 Needs Assessment, the MCH Program contracted with a consultant to conduct needs assessment activities, assist with building the state action plan, and perform data collection and analysis. The MCH program worked with partners and stakeholders to identify the CNMI's final priority needs, which included primary and secondary data collection, health themes, and stakeholder input on prioritization of the most significant health needs for the CNMI's families. An analysis of strengths, weaknesses, opportunities, and threats (SWOT analysis) was conducted. The final selection of priorities was based on programmatic capacity, evidence-base, cost, and feasibility in making measurable impact.

Based on the results of the 2020 needs assessment, the CNMI selected eight MCH Priorities across the respective population domains. The information below details the selected priorities for CNMI and the corresponding population domain and performance measure.

CNMI MCH leadership developed a state action plan with specific objectives and strategies to address the eight MCH priorities. The following sections present these objectives and an abbreviated description of notable strategies by each domain area.

WOMEN'S/MATERNAL HEALTH Access to health services was chosen as the priority for the women/maternal domain. It was the primary priority identified by the public input survey conducted in 2020, shows room for improvement based on the 2016 CNMI NCD data of only **43.2% of women reporting completing pap testing** within the past 2 years, and was ranked high for feasibility and impact as well as program capacity to affect change. Additionally, based on an MCH survey conducted in 2023 indicated that just **55% of women ages 18-44 years reported completing an annual preventive visit,** a slight decrease from 57% in 2022. Public input data suggested that screening for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues would be integrated into the women/maternal health visits to respond to this identified need. This priority aligns with National Performance Measure (NPM) #1- Well-woman visit.
Priority Need 1: Ability to find and see a doctor when needed (access to health services)

National Performance Measure 1: Percentage of women ages 18-44 years with a past year preventive visit.
Objectives: By 2025, increase the percentage of women who access preventive visits to 65%, an increase from the baseline of 55%.
Strategy: Expand access: Outreach and/ or increase clinic hours.
For FY2025, the CHCC PHS will conduct the following activities to improve women's health:

- **Utilize the CHCC mobile clinic to provide access to primary care and preventive screenings for women.**
- **Conduct community awareness activities to promote primary care and preventive screenings for women.**

INFANT HEALTH Through a stakeholder input survey of infant health priorities conducted in 2020, education and support for breastfeeding and prenatal care were identified as priorities for the CNMI. Early identification of developmental delays and the need for intervention services (ranked first), reducing infant mortality (ranked third), services and treatment for babies born exposed to certain substances such as alcohol or drugs (ranked fourth), and education and services to help prevent and care for premature babies (ranked seventh). These issues were combined into the following priorities for which MCH has program capacity to affect change. This combined priority ranked high for feasibility and impact. **First trimester prenatal care rates among CNMI resident women in 2022 was 62% and remained consistent in 2023 with 61% accessing prenatal care during the first trimester of pregnancy.** The CNMI infant mortality was at 13.8 per 1,000 live births in 2023, and increase from the rate of 12.7 per 1,000 in 2022. Because the CNMI does not have a level III neonatal intensive care unit, this priority will be a State Performance Measure (SPM) evaluated by early prenatal care.
Priority Need 2: Breastfeeding
National Performance Measure 4 – A) Percent of infants who are ever breastfed and
B) Percent of infants breastfed exclusively through 6 months
Objective: By 2025, increase of the percentage of infants breastfed through 6 months to 54%, an increase from the baseline of 44%.
Strategy: Implement workplace breastfeeding policies/support
For FY2025, the CHCC PHS will conduct the following activities to improve breastfeeding rates:

- **Make enhancements/modifications or customize the existing workplace breastfeeding toolkit identified for use to support the workplace breastfeeding initiative.**
- **Partner with 3 businesses/employers (2 government agencies and 1 private employer).**
- **Conduct survey of workplace breastfeeding initiative participation to gather feedback on implementation process and identify opportunities for improvement.**
- **Publish Community awareness products and other messaging to promote the workplace breastfeeding initiative.**

Priority Need 3: Prevention of adverse birth outcomes through Prenatal Care.
State Performance Measure 1: Percent of live births to resident women with first trimester prenatal care.
Objective: By 2025, increase the number of pregnant women with first trimester prenatal care to 75%, an increase from the baseline percentage of 55%.
Strategy: Provide service navigation for pregnant women.
For FY2025, the CHCC PHS will conduct the following activities to improve prenatal care rates:

- **Promote early prenatal care and access to prenatal service navigation in the CNMI community through social media, radio and newspaper advertisements.**
- **Provide training to clinic staff at the Tinian Health Center and Rota Health Center on service navigation for pregnant women so that services are also available on those islands.**
- **Increase partnerships to strengthen identification and referral of pregnant women for service navigation by providing in-service training and community outreach.**
- **Partner with Family Planning to promote free pregnancy testing to identify pregnant women early and connect with service navigation when needed.**

CHILD HEALTH The top three public input priorities from the 2020 stakeholder survey, information and support to help

children reach and stay at a healthy weight [obesity]; information and support about healthy eating options and how to make sure a family has enough food [nutrition/food security]; and safe schools and neighborhood programs, were combined into the priority identified below. The overall economics of the CNMI population makes food security and nutrition for children an explicit issue.

In addition, 31.5% of public input survey respondents in 2020 did not believe children of the CNMI have access to healthy physical activities. Although nutrition/ food security and obesity was ranked high for feasibility and impact as well as program capacity to affect change, safe schools and neighborhood programs was not.

In 2019, it was estimated by data collected on an MCH survey that 53% **of children ages 6 through 11 years in the CNMI were reported by their parents to be physically active at least 60 minutes per day**. In 2021, this rate decreased to 43.5 percent and then increased to **60.7 percent in 2023.**

Though the CHCC has limited capacity to affect change to physical and structural barriers, it was determined that promotion of the safe physical activity options that do exist was a valid priority for this population. This priority aligns with NPM #8- Physical activity.
Priority Need 4: Obesity related issues including nutrition and physical activity
National Performance Measure 8- Percent of children ages 6 through 11 years who are physically active at least 60 minutes per day.
Objective: By 2025, increase the percentage of children ages 6 through 11 years who report being active at least 60 minutes a day to 63%, an increase from the baseline percentage of 53%.
Strategies: 1) Increase the number of families who enroll in and evidence nutrition and physical activity program; 2) Increase community awareness on the importance physical activity for children.
For FY2025, the CHCC PHS will conduct the following activities to improve rates of physical activity among children 6 through 11 years:

- **Support the Public Health Non-Communicable Disease Programs to identify community partners to engage in sports clinic planning and nutrition education programming**
- **Work with community partners to develop a monthly calendar of sports clinic events and nutrition education sessions**
- **Promote sports clinics and nutrition education programming in the CNMI**
- **Conduct a monthly meeting or provide monthly updates to community partners on sports clinics and nutrition education outcomes, attendance/participation rates.**
- **Conduct post event or post session evaluations to gather input or feedback from community members for improving the quality and impact of physical activity and nutrition focused programming.**
- **Develop, revise, finalize and publish social media advertisements, TV commercial content, radio scripts, and newspaper content layout.**

ADOLESCENT HEALTH It was determined that screening for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues would be integrated into the adolescent health visits to response to this identified need. Both the original and the adolescent specific surveys showed that coping skills, suicide prevention and mental and behavioral health in general are of utmost importance. In addition, 2021 CNMI YRBS data shows that 29% of CNMI high school student reported seriously considering attempting suicide, a slight increase from 28.5% reported in 2019. Suicide prevention was also ranked high for feasibility and impact as well as program capacity to affect change during the 2020 CNMI comprehensive MCH needs assessment. This priority aligns with NPM #10- Adolescent well-visit. MCH intends to promote well visits for adolescents at which a holistic approach including promoting coping skills and preventing suicide as part of a behavioral health screening and assessment to be conducted at the well-visit.
In addition, Priority Need 7, Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful was determined to be an area of focus for adolescents with and without special healthcare needs that needed to be addressed.
Priority Need 5: Coping Skills and Suicide Prevention

National Performance Measure 10: Percent of adolescents, ages 12 through 17 years, with a preventive medical visit in the past year.
Objective: By 2025, increase the percentage of adolescents who access well visits to 55%, an increase from the baseline of 42%.
Strategy: Partner with the Public School System to increase the number of adolescents accessing preventive visits.
For FY2025, the CHCC PHS will conduct the following activities to support coping skills and suicide prevention for adolescents:

- **Partner with the CNMI PSS to develop an outreach schedule for school-based presentations, screenings, and referrals for accessing adolescent well visits**
- **Expand outreach and screenings to include more public high schools**

Priority Need 7: Support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful.
National Performance Measure 12: Transition- Percent of adolescents with and without special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care.
Objective: By 2025, increase the percentage of adolescents ages 12 through 17 years with and without special healthcare needs who receive transition services to 74% and 61%, respectively, an increase from baseline percentages of 51% and 48%, respectively.
Strategy: Provide education, presentations, and support to high school students and/or their parents in making transition into adult healthcare.
For FY2025, the CHCC PHS will conduct the following activities to improve the percentage of teens accessing transition services:

- **Work with youth serving partners to provide education and information to parents/caregivers and teens they serve regarding transition into adult healthcare**

CHILDREN WITH SPECIAL HEALTHCARE NEEDS (CSHCN) Coordinated care and assisting parents and caregivers navigate the health care system was chosen as the priority for the children with special health care needs domain. It was the primary priority identified by the public input survey, shows room for improvement based on the data from the CNMI MCH survey identifying **only 14.1% of children with special health care needs reported having a medical home,** the vast array of programs and agencies that contribute to services in this domain, and was ranked high for feasibility and impact as well as program capacity to affect change. This priority aligns with NPM #11- Medical home.
Priority Need 6: Helping parents/caregivers navigate the healthcare system
National Performance Measure 11: Percent of CSHCN ages 0 through 17 years who have a medical home.
Objective: By 2025, increase the percentage of CSHCN who report having a medical home to 25%, an increase from a baseline percentage of 13%.
Strategy: Strengthen partnerships with the CNMI Disability Network Partners (DNP) to establish referral mechanisms to connect CSHCN to medical homes.
For FY2025, the CHCC PHS will conduct the following activities to improve the percentage of CSHCN that report having a medical home:

- **Conduct Outreach & In-Service presentations to Parent Teacher Student Association (PTSA), school teachers/staff and high-school clubs.**
- **Strengthen partnership with DNP members by providing updates on the number of families accessing peer supports, training and other events that help connect children to medical homes.**
- **Conduct evaluation or feedback survey on presentations and peer support services.**
- **Conduct outreach in Rota and Tinian to enroll potential parent leaders for F2F HIC as part of efforts to connect families and children on those islands to medical homes.**

SYSTEMS BUILDING Building workforce capacity to improve the maternal and child health services in the CNMI was chosen as priority need 8. Participants voiced a need for trained, qualified professionals who could deliver services across

domains. This incorporates the survey findings related to priority, family engagement and parent education. The second priority topic chosen by respondents was better and clearer communication about healthy behaviors, health services and supports available in the community. Community outreach was chosen as the preferred method for family engagement with 72.7% of respondents choosing that method. Home visiting was chosen as the preferred method of receiving parent education with 57.6% of respondents choosing that method.

Priority Need 8: Professionals have the knowledge and information to address the needs of maternal and child health populations

State Performance Measure 2- Percentage of CHCC Public Health Services (PHS) staff who complete training on MCH priorities and related topics.

Objectives: By 2025, increase the number of CHCC Public Health staff (PHS) who complete training on MCH priorities and topics by 25% from baseline.

Strategy: Provide training to CHCC Public Health staff on MCH priorities and other related topics.

For FY2025, the CHCC PHS will conduct the following activities to increase the number of PHS staff that complete training on MCH topics:

- **Implement a learning management system to provide training and capture completion rates**

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

MCH Block Grant funds are used to support the overall MCH efforts in the Northern Mariana Islands. Primarily, Block Grant funds support Enabling Services to improve and increase access to health care and improve health outcomes of the CNMI MCH population. The types of enabling services supported include: Care/Service Coordination for pregnant women and Children of Special Healthcare Needs, Laboratory Supplies for Newborn Screening, Eligibility Assistance, Contraceptive Supplies, Health Education and Counseling for Individuals, Children, and Families, Outreach, and Referrals.

Public Health Services and Systems are also supported through MCH Block Grant dollars. Supporting activities and infrastructure to carry out core public health functions in the CNMI is critical for the efforts being made towards improving population health. Specifically, MCH Block Grant funds are used to support policy development, annual and five-year needs assessment activities, education and awareness campaigns, program development, implementation and evaluation. Additionally, funds are used to support workforce development towards building capacity among MCH staff, nurses, and partners who impact CNMI Title V priorities.

III.A.3. MCH Success Story

Family engagement in MCH Title V work continues to expand in the CNMI. In FY2023, MCH partnered with Dr. Patrick Castillon, a 5th grade Public School educator and his wife Leah Castillon. Both are active Parent Leaders who support activities for families of Children with Special Healthcare Needs (CSHCN) out of the Family to Family (F2F) Health Information Center. Samuel, their youngest child is diagnosed with Down Syndrome and both Mr. and Mrs. Castillon work to promote awareness about the condition in the CNMI. Working with the F2F, they spearheaded the development of the CNMI Support Group for families of children with Down Syndrome. In FY2023, the support group had 4 active families who participated and completed 8 support meetings.

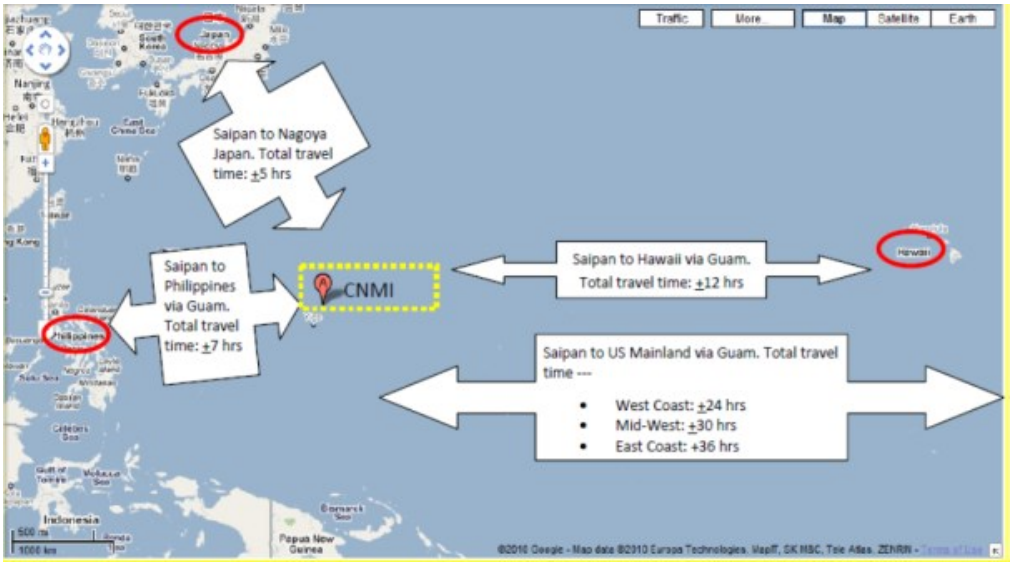
Contributed Photo: Dr. Castillon & family

In addition to the support group, he and his family coordinate events such as playdates at the park, read aloud at Headstart centers and wear crazy socks on Wednesdays to promote Down Syndrome awareness. Wanting to reach out to more families, he also worked with CNMI F2F Family Support Specialist on a social media campaign to further promote awareness. The awareness materials were shared on the CHCC Public Health Services social media accounts as well as disseminated via WhatsApp messaging.

The CNMI MCH Title V continues to prioritize effective partnerships with parent leaders such as Dr. Castillon and Leah Castillon. In FY2023, the MICAH Programs provided stipends to parent leaders to compensate for their time, a venue to conduct support group meetings, and staff time to develop and publish awareness materials.

III.B. Overview of the State

The Commonwealth of the Northern Mariana Islands (CNMI) is a U.S. Commonwealth formed in 1978, formerly of the United Nation's Trust Territory of the Pacific region of Micronesia within Oceania. The CNMI is comprised of 14 islands with a total land area of 176.5 square miles spread out over 264,000 square miles of the Pacific Ocean, approximately 3,700 miles west of Hawaii, 1,300 miles from Japan, and 125 miles north of Guam. The CNMI's population lives primarily on three islands; Saipan, the largest and most populated island, is 12.5 miles long and 5.5 miles wide. The other two populated islands are Tinian and Rota, which lie between Saipan and Guam. The nine far northern islands are very sparsely inhabited with few year-round inhabitants and no infrastructure services. The islands have a tropical climate, with the dry season between December and June, and the rainy season between July and November. Due to the CNMI's position in the Pacific Ocean, the islands are vulnerable to typhoons. There are also active volcanoes on the islands of Pagan and Agrihan. Saipan, Rota and Tinian are the only islands with paved roads, and inter-island transport occurs by plane or boat.



In October 2011, Public Law 16-51 dissolved the Department of Public Health and created the Commonwealth Healthcare Corporation (CHCC). CHCC is a quasi-governmental corporation, and while it is a part of the CNMI Government, it is semiautonomous. The CHCC is the operator of the Commonwealth's healthcare system and the primary provider of healthcare and related public health services in the CNMI. This law transferred all the functions and duties of the CNMI Department of Public Health including management of federal health related grants to the Commonwealth Healthcare Corporation, so that the CHCC is the successor agency to the now defunct Department of Public Health. The only hospital in the CNMI is also administered by CHCC. The CHCC is governed by a Board of Trustees and managed by the Chief Executive Officer (CEO) of CHCC. The CEO is the authorized representative for all federal grants, including the CNMI MCH Title V Program. On December of 2023, the CHCC underwent a re-organization to better align and improve the integration of services and functions leading to the fulfillment of the CHCC's overall mission. As a result, the re-organization consists of the following sections: 1) Executive Administration, 2) Financial, 3) Business & Quality Assurance, 4) Ancillary & Support Services, 5) Medical, 6) Population Health, and 7) Nursing. Under each domain there are main functional areas and/or service lines assigned with the intent to establish a unified oversight, accountability, and implementation of a system approach. The approach to population health was revamped and expanded as a core functional area under the organization that includes the integration of the following services: Clinical, Public Health Services and Mental Health Services, along with its assigned management accountability that all work together to improve and optimize the health of our community and therefore, population. The CNMI MCH Title V Program falls with the Population Health Services section and administered under the oversight and direction of the Director of Public Health Services.

Demographics

2020 US Census Update for the Northern Mariana Islands

In October of 2021, the US Census Bureau released data on the population of each municipality and district for the Northern Mariana Islands, and the population change between 2010 and 2020. Table 3 below outlines the changes in the population highlighting a 12.2% decrease in the total population for the Northern Mariana Islands. Population change by island includes a 34.8%, 25.1%, and 10% decrease in the population sizes for the islands of Tinian, Rota and Saipan, respectively[i].

Table 1. Population of the Commonwealth of the Northern Mariana Islands: 2010 and 2020

Geographic area	Population		Change (2020 less 2010)	
	2010	2020	Number	Percent
Commonwealth of the Northern Mariana Islands	53,883	47,329	-6,554	-12.2
Northern Islands Municipality	0	7	7	X
District 4	0	7	7	X
Rota Municipality	2,527	1,893	-634	-25.1
District 7	2,527	1,893	-634	-25.1
Saipan Municipality	48,220	43,385	-4,835	-10.0
District 1	15,160	13,633	-1,527	-10.1
District 2	6,382	5,489	-893	-14.0
District 3	15,624	14,115	-1,509	-9.7
District 4	3,847	3,416	-431	-11.2
District 5	7,207	6,732	-475	-6.6
Tinian Municipality	3,136	2,044	-1,092	-34.8
District 6	3,136	2,044	-1,092	-34.8

Source: US Census Bureau

Single ethnic groups that accounted for the majority population in the CNMI were identified as Filipino (33 percent), followed by Chamorro (25 percent) and Chinese-except Taiwanese (7 percent). Carolinians make up about 5 percent of the total population. Asians were the largest group representing nearly half of the total population. Other Asians make up 7 percent of the total population. Native Hawaiian and Other Pacific Islanders made up about 14 percent and Caucasians less than 2 percent. About 7 percent of CNMI's population were of two or more ethnic origins or races and All Others. In the CNMI, the Chamorro and Carolinian groups are the native indigenous groups of the territory.

Table 2 provides a breakdown of the MCH population based on data from the 2020 US Census and Table 3 illustrates the historical U.S. census data for the MCH population and CNMI population by ethnicity respectively.

Table 2: MCH Population in 2020

Population	2020	% of total Population
Under 5 years	3,218	6.8
Children (5- 14)	7,920	16.7
Adolescents (15-19)	3,834	8.1
Women (15-44)	9,237	19.5

Source: U.S. Census Bureau

Table 3: CNMI Population by Ethnicity, 1990 – 2020.

Ethnicity	1990	2000	2010	2020
Chamorro	12,555	14,749	12,902	12,001
Carolinian	2,348	2,652	2,461	2,271
Filipino	14,160	18,141	19,017	15,456
Chinese	2,881	15,311	3,659	3,270
Caucasian	875	1,240	1,343	1,015
Other Pacific Islanders	3,663	4,600	3,437	6,393
Other Asians	4,291	5,158	4,232	3,328
Others	2,572	7,370	6,832	3,595

Source: U.S. Census Bureau

CNMI has a large percentage of the population that are uninsured. The 2020 U.S. Census reports the uninsured population in the CNMI at 35 percent, while the uninsured rate in the United States is at 8.4 percent[ii]. A challenge with the uninsured population is the status of the immigrant contract workers who are ineligible for Medicare and Medicaid. In the CNMI, based on 2020 US Census data, residents with Medicaid/public coverage constitute about 35 percent of the population, while the Medicaid rate of the U.S. at 21.1 percent[iii].

Economy

Since 1998, the CNMI's economy has suffered one long continuous, downward spiral. A variety of factors contributed to the current circumstance, including the loss of tourism-related business, the effects of rising fuel costs across all of the CNMI, the closing of the garment manufacturing industry, and the implementation of federal Public Law 110-229, which removed local control over immigration. In 2020, the United States Government Accountability Office (GAO) published a report to US congressional committees which indicated growth in the CNMI's economy in 2016 and 2017, based on estimates of gross domestic product (GDP). However, the GAO reports a drop in GDP as a result of sharp decreases in tourist spending following severe damages to the CNMI caused by super typhoon Yutu in 2018[iv]. Real gross domestic product (GDP) for the CNMI decreased 29.7 percent in 2020 after decreasing 11.3 percent in 2019. Furthermore, the CNMI economy was substantially affected by the COVID–19 pandemic due to its effects on spending by consumers, visitors, businesses, and governments[v].

According to the 2020 U.S. Census, the median household income increased from $23,839 in 2009 to $31,362 in 2019. The percentage of families in poverty decreased from 44.4 percent in 2009 to 33.7 percent in 2019. However, it should be noted that 38 percent of the total CNMI population and 42 percent of families with children below 18 years of age reported incomes below the poverty level. In comparison, the US Census Bureau reports 11.6 percent of the population in the US live under the poverty level[vi].

Healthcare for the MCH Population

Commonwealth Healthcare Corporation (CHCC)

The sole hospital in the Commonwealth of the Northern Mariana Islands (CNMI) was initially established as the Department of Public Health and Environmental Services (DPH) in 1978 by Public Law 1-8. In 2009, DPH was re-organized into the Commonwealth Healthcare Corporation, a public corporation, under the "Commonwealth Healthcare Corporation Act of 2008" by Public Law 16-51. The CNMI established the Commonwealth Healthcare Corporation (CHCC), a public corporation in 2011. The organization of both clinical and public health services in a public corporation is unique in the United States. The CHCC is responsible for the Commonwealth Health Center hospital; ancillary services; the Rota and Tinian Island Health Centers; and mental health and Public Health functions and programs.

The Commonwealth Legislature cited a desire for the hospital to be an "independent public health care institution that is as

financially self-sufficient and independent of the Commonwealth Government as is possible." Although the CHCC now exists as a quasi-independent institution, it remains a public corporation charged with the responsibility of providing essential health care to the people of the CNMI. Yet, since its inception, the CHCC has struggled with the transition from a government agency to a public corporation. And while the CHCC has made progress the past several years in expanding services and increasing access to healthcare, the large uninsured population coupled with minimal funding support from the CNMI government to address indigent care costs continues to challenge the CHCC.
By the end of 2023, the CHCC had an estimated 950 personnel employed. The CHCC provides 100 percent of inpatient services and roughly 80 percent of ambulatory services in CNMI.

- *Services for Pregnant Women, Mothers, Infants*

The Women's and Children's Clinics located at Commonwealth Health Center (CHC) provides comprehensive primary and preventive services for MCH target groups. There are currently five OB/GYN working at the CHCC Women's Clinic and two mid-level providers. There are currently eight pediatricians and one mid-level provider at CHCC. The MCH Program supports services at both clinics such as case management of high-risk patients, development of educational materials including posters and brochures, and provides staff to assist with developmental screenings and health coverage applications. The HIV/STD screening program, Family Planning Program, and Breast and Cervical Cancer screening program are also offered through the Women's Clinic. Dental health services are made available to women and infants through the CHCC Dental Clinic. Additionally, the CHC hospital maintains the CNMI's only emergency room department and birthing facility and includes the following inpatients units: Obstetrics, Nursery, NICU, Labor & Delivery, Pediatrics.
Behavioral health services such as substance use treatment services, counseling, and other behavioral health supports are available via the Community Guidance Center or the Psychiatry providers accessed via the outpatient clinics. Oncology services became available to the CNMI community in 2020 with the first CNMI Oncology Center being established. Again, MCH Program provides enabling services such as transportation, translation, referrals, incentives, community awareness, and educational materials. Through home visiting initiatives, the MCH Program helps families navigate through state programs. Majority of families seek assistance for WIC, NAP, and Medicaid.

- *Services for Children and Adolescents*

Primary and preventive healthcare services for children and adolescents are provided at the Children's Clinic. Confidential sexual and reproductive healthcare for adolescents is offered through the Family Planning program through service sites at the Women's Clinic, Rota Health Center, Tinian Health Center, and during clinic outreach events. Dental health services are also provided at CHCC Dental Clinic. Vaccinations are made available through the Immunization and Vaccines for Children (VFC) program, which oversees enrollment of VFC sites throughout the CNMI. VFC sites, which include private clinic providers, provide vaccinations to children and adolescents.

- *Services for Children and Youth with Special Health Care Needs*

One of the main challenges with the CNMI special needs population is the lack of specialty care on island. Families are referred off-island for medical care which adds financial burden. Through partnerships with Shriners Hospital in Honolulu and the Public School System certain specialty care are offered on island including Audiology, ENT, and selected surgeries. The Shriner's Children's Hospital of Honolulu conducts clinic outreach to the CNMI twice a year.

Early intervention services for infants and toddlers with special healthcare needs ages zero to three years are provided through a collaborative effort of the CNMI Public School System and the Commonwealth Healthcare Corporation. Funding for services for early intervention services is provided through Part C of the Individuals with Disabilities Act. The CNMI Public School System is designated by the CNMI Governor as the Lead Agency for carrying out the general administration, supervision, and monitoring of the early intervention program and activities in the CNMI. Services for children with special healthcare needs age three to five years are provided through the CNMI Public School System's Early Childhood Program and for those ages five through 21 years through the Part B, Special Education Program. The following services are

available for children with special healthcare needs in the CNMI: audiology services, occupational therapy, physical therapy, service coordination, sign language services, speech-language pathology services, vision services, psychological services, and counseling. According to the CNMI Public School System School Year 2022-2023, 1,094 children with special needs were served. There were 76 infants and toddlers enrolled in Early Intervention Services, 84 children ages 3-5 served through early childhood special education, and 934 children and adolescents ages 6-21 were served through special education[vii]. As a joint effort formalized through an Interagency Agreement, the CHCC MCH Program provides service coordination for infants and toddlers who are enrolled in Early Intervention Services. The CNMI Title V MCH Program facilitates and/or supports programs for the early identification of children from birth through five and supports referrals of children with special healthcare needs to Early Intervention services. For school year 2023- 2024, there were a total of 170 referrals made to the Early Intervention program, with 82 qualifying for services of which 68 were identified with a developmental delay and 14 were qualified due to an established condition.

Rota Health Center

The Rota Health Center (RHC) is the only medical facility on the island of Rota and services the entire population of roughly 1,800. Presently, medical providers from the CHCC Family Care Clinic rotate into the RHC to provide care to patients seen at the RHC outpatient clinics. Rotating Emergency Department medical providers from Saipan are scheduled to provide care to urgent care or walk-in patients. The RHC currently has five nurses, one laboratory technician, one phlebotomist, two pharmacy technicians, one radiologic technician, and one dental assistant. In FY 2023, the RHC was successful in expanding oral health services for the residents of the island with the recruitment of a full time Dental Therapist.
The Rota Health Center has emergency, outpatient clinic, pharmacy, laboratory, and radiology units. Public Health services such as Family Planning Program, Breast and Cervical Cancer Screening, and HIV/STD Screening are available at the Rota Health Center.

Tinian Health Center

The Tinian Health Center is located on the island of Tinian and services the entire population of roughly 2,000. At present, the Tinian Health Center has two nurse practitioners. The Tinian Health Center operates an emergency, outpatient clinic, pharmacy, laboratory, and radiology units. Public Health services such as Family Planning Program, Breast and Cervical Cancer Screening, and HIV/STD Screening are available at the Tinian Health Center.

Mobile Clinic Services

In the fall of 2022, the CHCC began offering primary and preventive health services via a mobile clinic. Prior to 2022, the last time mobile clinic services were provided on Saipan was in 2018, prior to typhoon Mankhut and Yutu. In 2020, the CHCC began the procurement process to purchase a new and larger mobile clinic unit to as part of efforts to expand access to preventive health services and for reaching the underserved within the population. The CHCC mobile clinic serves as an extension of the outpatient clinic services available via CHCC and offers routine adult, well-woman, well child, family planning services. Community Health Workers (CHWs) were recruited to coordinate outreach services and to work with medical providers from the outpatient clinics in scheduling outreach events. The CHCC mobile clinic services the island of Saipan. During FY 2023, the mobile clinic served a total of 367 women from ages 20 – 60+ years for services that included: health screening, immunizations, and women health checks. Additionally during the same time period, the mobile clinic served a total of 171 children from ages 0 – 19+ years for well child health checks and immunizations.

Federally Qualified Health Center (FQHC)

Kagman Community Health Center (KCHC)

The establishment of the Kagman Community Health Center, a federally qualified health center (FQHC), in 2012 located in one of the remote villages in the southeast part of Saipan has improved access to healthcare services for the MCH population. The KCHC provides outpatient services such as: general primary care, basic diagnostic laboratory, screenings,

family planning, well-child, gynecological care, obstetric care, preventive dental, case management, health education and outreach.

Tinian Isla Community Health Center (TICHC)
In 2020, an additional FQHC was opened on the island of Tinian. Tinian Isla Community Health Center provides outpatient services such as: general primary care, basic diagnostic laboratory, screenings, family planning, well-child, gynecological care, obstetric care, preventive dental, case management, health education and outreach to the community that resides on Tinian.

The CHCC Division of Public Health is prioritizing formalizing partnerships with the CNMI FQHCs as part of efforts to improve access to preventive and primary care services for the MCH population in the CNMI through collaboration and coordination of services. In April of 2024, an agreement outlining a partnership for expanding vaccinations, particularly for the CNMI child and adolescent population, between the CHCC Public Health and the CNMI FQHCs was completed. Efforts to expand and improve partnership between the health department and the FQHCs continue.

Private Clinics
In addition to the CHCC clinics and the FQHCs, the CNMI has five private clinics that also provide preventive healthcare to the MCH population. The CNMI currently has 7 private dental clinics on the island of Saipan.

Challenges that Impact Access to Healthcare

There have been cuts in services including staff as a result of the transition of the Department of Public Health to the Commonwealth Healthcare Corporation. Federal public health grants have been the primary source of funding for services, activities, and infrastructure for programs in the Division of Public Health Services. The budget cuts, combined with issues surrounding federal immigration policies for healthcare staff causes impedance to securing or retaining nearly any type of medical personnel. The CNMI is also a Health Professional Shortage Area (HPSA) for primary care, dental, and mental health and a medically underserved area. The CNMI licensure regulations require that physicians and mid-level providers hold United States medical credentials in order to practice medicine in the CNMI.

Uninsured Population
CNMI has a large percentage of the population that is uninsured. The rate of uninsured population in the CNMI is at 35 percent, according to the most recent US Census estimates for 2020 that was released in 2022. There essentially was no change in the uninsured rate compared to the 2010 estimate of 34 percent. In 2013, CNMI Public Law 17-92 was passed, which released employers from the responsibility for providing health insurance coverage to non-U.S. qualified workers (legally-present foreign workers). The estimated percentage of foreign workers in the CNMI is 41 percent[viii], a significant percentage of the workforce.

Inter-Island Medical Referral Services
The Tinian Health Center and the Rota Health Center, which is under the CHCC organizational structure has limited providers and no specialized services. Inter-island referrals are covered by the CHCC and the Mayor's Office of Rota or Mayor's Office of Tinian. The CHCC pays for the airfare of patients referred from Tinian or Rota and the respective Mayor's Office pays for the hotel and subsistence expenses for the patient and escort.

Off-island Referrals
On January 31, 2023, Public Law 22-33 was signed into law, transitioning the Medical Referral Office from the CNMI Office of the Governor to the Commonwealth Healthcare Corporation. The Medical Referral program now operates as the Health Network Program providing airfare, housing, and transportation assistance to qualified individuals.
Treatment services, including access to diagnostic services, not readily available in the CNMI are handled through the CNMI Health Network Program (HNP), which was formerly known as the Medical Referral Program. Patients are referred to

healthcare facilities in Guam, Philippines, Korea, Taiwan, Hawaii, or the US mainland. In 2004 the number of off-island medical referrals was 437 patients and since that time the number of referrals has increased steadily to 565 patients in 2007, 924 patient referrals in 2009, and 1,117 patients in 2010. There was a 155% increase in the number of patients referred for off-island care between 2004 and 2010. In an interview with the CNMI Medical Referral Office Director, Ronald Sablan, it was noted that the rise in medical referral patients is largely attributed to a lack of medical maintenance among patients. Patients are increasingly forgoing preventive care and seeking medical attention when health conditions or diseases are at their worst stages and requiring care not readily available on island[ix]. An economic crisis that began in the year 2000 impacted both the CNMI population's ability to be able to access healthcare, more importantly, preventive healthcare and government spending, including spending on healthcare. In the year 2000, the CNMI's garment manufacturing industry began to slowly close its doors until it eventually completely phased out in 2006. In addition to this, tourism, the CNMI's second largest industry experienced a major decline in the early 2000's. Economic recovery was noted by growth in gross domestic product beginning in 2012 through 2016 and the tourism sector reporting visitor arrivals increases of 39.9% over the four-year period[x]. However, the improvements in the tourism market were short lived when the CNMI was devasted by Super Typhoon Yutu in 2018 and further impacted by the COVID-19 pandemic. It has been noted that a priority for addressing the challenges to the CNMI economy is to restore the visitor industry. Studies have shown that unemployment rates are linked to preventive healthcare utilization, with increases in unemployment corresponding to decreases in individuals completing preventive health services such as pap smears, mammograms, and annual checkups[xi].

Recent data made available to Public Health from the CNMI HNP indicates that in 2021, there was a total of 741 referrals for medical care outside of the Northern Mariana Islands, this is a decrease from 941 in 2020, and 1,788 and 1,815 in 2019 and 2018 respectively.

A large majority (66%) of the referrals in 2021 were sent to the neighboring island of Guam, with MRI studies and cardiology being the major reasons for referral. Overall, the major health categories for referrals include cardiology, MRI studies, radiology, and ophthalmology.

Health Coverage for MCH Population

As a territory, enrollment in the ACA is not available. However, enrollment into the Medicaid program is enhanced for eligible persons. The CNMI Medicaid program is unique to the CNMI and other US territories and jurisdictions. The program is "capped" by the US federal government and limited to a set dollar amount allotted to the CNMI. This limited funding severely affects access, cost, and quality of health care for all residents of the CNMI. The current state plan limits use of CHIP money to the event where the general program has exhausted its standard funding. This is a federal restriction imposed on the CNMI based on information verified by local health officials. CHCC is the primary provider for all Medicare and Medicaid beneficiaries in the CNMI, thus restrictions on services are currently enforced on private clinics.

Medicaid

Medicaid was first implemented in 1979 and covers approximately 16,000 lives in the CNMI (about one quarter of the CNMI population) and uses Supplemental Security Income (SSI) as the resource threshold rather than the federal poverty level (FPL) as in most states. As a result, the maximum resource eligibility for the CNMI Medicaid program is slightly less than 100 percent of the FPL. Medicaid is furnished to SSI beneficiaries, and income-eligible individuals who are U.S. citizens, or "qualified aliens" defined under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), or non-qualified aliens for treatment of emergency medical condition, or lawfully present pregnant women.

The framework for Medicaid financing in the CNMI resembles that of the fifty states: the cost of the program (up to a point) is shared between the federal government and the Territory and the federal government pays a fixed percentage of the CNMI Medicaid costs. However, unlike the 50 states, the federal government pays a fixed percentage of the CNMI Medicaid costs within a fixed amount of federal funding. If CNMI Medicaid expenditures exceed the territory's federal Medicaid cap, which was $6.3 in FY 2017, the CNMI becomes responsible for 100 percent of Medicaid costs going forward. This situation results

in the suspension of healthcare services or the ceasing of payments to providers until the next fiscal year. Moreover, the CNMI historically has received a relatively low fixed percentage, which is known as the Federal Assistance Percentage, or FMAP. The FMAP rate for the CNMI is set at 55%, lower than most of the 50 states. This means that the CNMI will get 55 cents back from the federal government for every dollar spent on the Medicaid program up to the federal cap. The formula by which the FMAP is calculated for the 50 states is based on the average per capita income for each state's relative to the national average. Thus, the poorer the state, the higher the federal share, or FMAP, is for the jurisdiction in a given year. However, due to the statutory restrictions on Medicaid financing for the Northern Mariana Islands, the FMAP that was provided the CNMI is not based on per capital income of residents, thus, the CNMI's FMAP does not reflect the financial need of the CNMI in the same ways that the 50 states' financial needs if represented. Through a number of legislations made recently, the FMAP rate for the CNMI was temporarily increased from 55% to 83% from FY2020 through FY2022. In December of 2023, the Consolidated Appropriations Act of 2023 made the 83% FMAP rate for the CNMI permanent, along with most of the other territories.

According to the Medicaid and CHIP payment and Access Commission (MACPAC), in fiscal years 2011 thru 2017, the federal spending for Medicaid in the Northern Mariana Islands exceeded the annual funding ceiling. This spending reflects the use of the additional funds available under the PPACA. The CNMI Medicaid Office had exhausted the additional funds made available by the PPACA in April 2019. However, recent supplemental federal funds have been made to the CNMI, beginning with the FY2020 appropriations package, signed into law in December 2019 and then the Families First Coronavirus Response Act, effective March 2020.

These supplemental funds raised the CNMI's FY2020 Medicaid funding allotments From $6.9 million to $63.1 million, FY 2021 allotment from approximately $7.1 million to $62.3 million, and the FY 2022 allotment to $64 million. For FY 2022, the Centers for Medicare & Medicaid Services (CMS) interpreted the effect of the supplements that provided federal Medicaid funding to the territories comparable to the annual federal capped funding provided for FY 2021. This resulted in the FY2022 and FY2023 Medicaid cap for the CNMI being placed at $64 million and $66 million respectively.

Private Insurance
There are several private insurance companies (StayWell, TakeCare, SelectCare, Moylan's NetCare, Aetna) in the CNMI that provide health insurance to the local government, other employers, and the general public, but individual health insurance plans are not guaranteed to be available to all residents. Private health insurers in the CNMI are not restricted from denying coverage due to health status or other factors.

Policies and Regulations that impact MCH Populations

Public Law 01-33 School Immunization Act of 1979.

Public Law 06-10 "to provide for an elected Board of Education to establish an autonomous education system in the Northern Marianas"

Public Law 11-75 "…to increase enforcement of and the penalties for the provision of tobacco to minors or the use of tobacco by minors…"

Public Law 12-75 "To require the Commonwealth Health Center to provide free counseling and screening of pregnant woman in order to prevent the prenatal transmission of Human Immunodeficiency Virus (HIV) and to provide for clear authority for medical care providers to provide medical care related to the testing and counseling of sexually transmitted diseases, who request such care without parental consent."

Public Law 13-58. CNMI Health Improvement Act of 2003. For monies in the Tobacco Control Fund to implement programs and services as follows: (a) Department of Public Health for the CNMI Comprehensive State-Based Tobacco Control Program, the CNMI Chronic Disease-Diabetes Control Program, the CNMI Cancer Registry, the Breast and Cervical Cancer Program, and the Bureau of Environmental Health for the enforcement of local tobacco control regulations; (b) CNMI Office of the Attorney General for overseeing the Master Settlement Agreement and future litigation; (c) Rota Health Center and the Rota youth organization; and (d) Tinian Health Center and the Tinian youth organization.

Public Law 15-50. The Vital Statistics Act of 2006. To adopt the "Model State Vital Statistics Act and Regulation Revision" as recommended by the National Center for Health and Statistics and the Centers of Disease Control to establish a uniform system for handling records that satisfy legal requirements as well as meet statistical and research needs at local, state, and national levels.

Public Law 16-46 "To prohibit smoking in all workplaces and public places, and for other purposes."

Public Law 19-23 "To define and prohibit electronic cigarettes where smoking is prohibited and to regulate electronic cigarettes by including it in the Tobacco Control and to prohibit minors who are under the age of 18 from using it."

Public Law 19-82 "To prohibit smoking in vehicles when in the presence of minors."

Public Law 22-33 "To establish the Health Network Program (HNP) under the Commonwealth Healthcare Corporation (CHCC); to provide for the orderly transition of medical referral services
administration and operations to CHCC; to write off outstanding balances of medical referral
promissory notes; and for other purposes."

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[i] United States Census Bureau. (2021) 2020 Island Areas Census: Commonwealth of the Northern Mariana Islands (CNMI). Retrieved on July 01, 2023 from https://www.census.gov/data/tables/2020/dec/2020-commonwealth-northern-mariana-islands.html

[ii] National Center for Health Statistics. (2023). Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2022. Retrieved on July 16, 2023, from https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202305_1.pdf

[iii] Kaiser Family Foundation. (2023). Percent of People Covered by Medicaid or CHIP, 2021. Retrieved on July 16, 2023 from https://www.kff.org/interactive/medicaid-state-fact-sheets/

[iv] Unites States Government Accountability Office. (2020). Commonwealth of the Northern Mariana Islands Recent Economic and Workforce Trends. Retrieved on July 16, 2023 from https://www.gao.gov/assets/gao-20-305.pdf

[v] Bureau of Economic Analysis. (2023). Gross Domestic Product for the Commonwealth of the Northern Mariana Islands, 2020. Retrieved on July 16, 2023 from https://www.bea.gov/news/2023/gross-domestic-product-commonwealth-northern-mariana-islands-2020#:~:text=Real%20gross%20domestic%20product%20(GDP,of%20Economic%20Analysis%20(BEA).

[vi] Unites States Census Bureau. (2022). Poverty in the United States: 2021. Retrieved on July 16, 2023 from https://www.census.gov/library/publications/2022/demo/p60-277.html

[vii] CNMI Public School System. (n.d.). 2022-2023 Fast Facts and Figures. Retrieved on June 16, 2024 from https://www.cnmipssoare.org/ARE_programs/records_data_management/facts_figures

[viii] Unites States Government Accountability Office. (2020). Commonwealth of the Northern Mariana Islands Recent Economic and Workforce Trends. Retrieved on July 16, 2023 from https://www.gao.gov/assets/gao-20-305.pdf

[ix]

Deposa, M. (2014). Off-island Medical Referral on the Rise in CNMI. Saipan Tribune. Retrieved on August 26, 2018 from http://www.pireport.org/articles/2014/01/09/island-medical-referral-cases-rise-cnmi

[x] Conway, D. (2024). A short history of the CNMI economy. Saipan Tribune. Retrieved on July 05, 2024 from https://www.saipantribune.com/opinion/columnists/a-short-history-of-the-cnmi-economy/article_ec0d6572-b42a-11ee-801a-1b579c5ab4da.html

[xi] State-Level Unemployment and the Utilization of Preventive Medical Services, Nathan Tefft and Andrew Kageleiry. *Health Services Research*. Article first published online: 16 JUL 2013 | DOI: 10.1111/1475-6773.12091

III.C. Needs Assessment
FY 2025 Application/FY 2023 Annual Report Update

On-going Needs Assessment Activities

MCH continues to collaborate with the CHCC hospital, Health and Vital Statistics Office, and key partners such as the CNMI Public School System and WIC for improved data collection, analysis and reporting on the health and wellness outcomes of the CNMI MCH population. Participation is highly encouraged in partnership meetings with associates and stakeholders for gathering quality data in promoting programmatic activities. In addition, establishing membership with local groups and committees such as the Disability Network Providers (DNP), Early Intervention Services Program's Interagency Coordinating Council, and the Head Start Advisory Council (HSAC) provides MCH opportunities to network with agency partners for obtaining updates on annual plans, objectives, needs, and any emerging issues occurring through partner programs.

MCH continues to receive data from the health system primary care clinics, Health & Vital Statistics Office (HVSO), hospital admissions and Carevue Electronic Health Records for chart reviews and to help inform ongoing needs assessment processes.

The MCH Jurisdictional survey is a Federally available data (FAD) source used to gather valuable MCH data to inform annual needs assessment activities as well as serving as a data source for National Outcome Measures (NOMs) and National Performance Measures (NPMs). The MCH-JS was conducted in the CNMI three times, in 2019, 2021, and 2023. The MCH Jurisdictional survey provides data for 19 National Performance Measures and 14 National Outcome Measures for the Title V MCH Block Grant Programs.

In May 2021, the CHCC was awarded funding through the Centers for Disease Control and Prevention (CDC) to implement the Pregnancy Risk Assessment Monitoring System (PRAMS). The PRAMS collects jurisdiction-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. PRAMS surveillance currently covers about 81% of all U.S. births. The CNMI MCH will utilize the PRAMS data to investigate emerging issues and to plan and review programs and policies aimed at improving health outcomes for CNMI mothers and babies. The State Systems Development Initiative (SSDI) supports the PRAMS Integrated Data Collection System (PIDS) by using SAS software to generate monthly samples and summarize information in the dataset. In 2022, the PRAMS project sampled 373 birth records of the total 473 live births recorded in the CNMI. At the end of the Phase 8 data collection, the CNMI PRAMS project accomplished a 57.91% response rate. The CNMI received its first PRAMS weighted data set from the CDC on June 2024. The CNMI will work to develop a report on CNMI maternal health using the PRAMS data to share with organizational leaderships, community stakeholders, and policymakers.

Update on Health & Well-being Status/Needs of MCH Population

Women/Maternal Health

Data gathered from the MCH Jurisdictional Survey (MCH-JS) in 2023 indicates that an estimated 55 percent of women ages 18 thru 44 years reported completing a preventive health visit in the past year, a slight decrease from 57 percent in 2021 and 56 percent in 2019. Additionally, the total number of cervical cancer screenings conducted via pap smears in 2023 was 1,518, a decrease of 361 screenings conducted compared to the year prior. The percentage of women of reproductive age accessing preventive health service via the CNMI Family Planning Program increased to 15.4 percent in 2023 from a percentage of 13.1 in 2022. Among non-tourist pregnant women with live births in the CNMI, 61 percent in 2023 reported early prenatal utilization, which is a rate maintained from 2022 (62%). It is estimated that 3.3 percent of live births were to women who reported smoking in pregnancy, while 3.6 of the same population reported drinking alcohol in the last 3 months of pregnancy, an increase from 1.1 in 2022.

Perinatal/Infant Health

In 2023, the Health and Vital Statistics Office reported 581 live births in the CNMI, of which 66 percent of the births covered by Medicaid and 79 percent enrolled in WIC. Approximately 93 percent of infants were breastfed and 11 percent of infants were breastfed exclusively through 6 months, a significant increase from .5 percent in 2022. Additionally, 10.5 percent of infants were born with low birthweight, an increase of 1.8 percentage points from the previous year; and the percentage of infants born preterm is 10.5 percent, a decrease from 12.3 percent in 2022. The CNMI infant mortality rate for 2023 is 13.8 per 1,000 live births, a slight increase from the rate pf 12.7 per 1,000 in 2022.

Child Health

The 2023, MCH-JS indicated 60.7 percent of children ages 6 through 11 years were reported to be physically active at least 60 minutes per day, an increase from 43.5 percent in 2021. The percentage of children who were reported with decayed teeth or cavities on the MCH-JS in 2023 was 25.2 percent, an increase from 17.0 in 2021. Additionally, just 36.9 percent of CNMI children ages 1 through 17 years were reported to have completed a preventive dental visit in the past year, slightly higher than the pre-pandemic percentage of 31.5. but a decrease from 46.4 percent in 2021.

The percentage of parents in 2023 that reported their children (ages 0 through 17 years) to be in excellent or very good condition was 76 percent, a increase from 72 percent reported in 2021.
There was a decrease in the vaccination coverage among CNMI children ages 19 through 35 months for the combined 7-vaccine series between 2022 (69%) and 2023 (62%). High annual influenza vaccination coverage rates among CNMI children 6 months through 17 years is maintained 81 precent in 2023.

Adolescent Health

CNMI 2023 Maternal and Child Health Jurisdictional Survey data on the adolescent well-visits indicate that just 27.3 percent of adolescent ages 12 through 17 years had a preventive visit in the past year, a decrease from 39.3 percent in 2021. The teen birth rate among 15 to 19 years olds increased from 9.9 per 1000 in 2022 compared to 16.9 per 1000 in 2023.
Vaccinations among the CNMI adolescent population are also maintaining high coverage with 96 percent of teens ages 13 through 17 years with at least one dose of the HPV vaccine, 98 percent of the same group receiving at least one dose of the meningococcal conjugate vaccine and 98 percent receiving at least one dose of the Tdap vaccine.
Data for the 2021 CNMI Youth Risk Behavior Survey (YRBS) was released in the spring of 2023 providing updates on a variety of youth risk behavior for middle and high school students in the CNMI. Table 1, below, provides trend data for select indicators for the years 2015 thru 2021.

Table 1. CNMI YRBS Trend Data for select indicators, percent among High School Students, 2015 – 2021

Survey Question	2015	2017	2019	2021
Unintentional Injuries and Violence				
Were electronically bullied	15.4	17.3	14.2	15.4
Were bullied on school property	22.1	23.2	18.4	9.9
Felt sad or hopeless	36.2	40.7	47.7	54.6
Seriously considered attempting suicide	22.8	25.0	28.5	29.6
Made a plan about how they would attempt suicide	23.3	22.8	27.1	27.6
Actually attempted suicide	13.5	13.6	18.0	17.6
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	2.9	4.3	4.9	5.3
Tobacco Use				
Ever tried cigarette smoking	54.9	45.2	44.8	35.6
Currently smoked cigarettes	17.9	12.4	10.8	6.9
Currently smoked cigarettes daily	2.8	2.5	1.9	1.4
Ever used electronic vapor products	53.3	53.6	64.5	56.1
Currently used electronic vapor products	26.3	13.7	24.4	26.4
Currently used electronic vapor products daily	2.0	1.9	4.1	7.8
Sexual Behavior				
Were currently sexually active	29.0	24.3	23.6	17.5
Did not use a condom during last sexual intercourse	54.2	47.4	61.0	61.9
Did not use both a condom during last sexual intercourse and birth control pills; an IUD (e.g., Mirena or ParaGard) or implant (e.g., Implanon or Nexplanon); or a shot (e.g., Depo-Provera), patch (e.g., OrthoEvra), or birth control ring (e.g., NuvaRing) before last sexual intercourse	--	--	--	94.7
Physical Activity				
Were not physically active at least 60 minutes per day on 5 or more days	56.6	62.8	63.5	71.8
Spent 3 or more hours per day on screen time	--	--	--	77.6
Did not attend physical education (PE) classes on all 5 days	70.2	71.5	73.8	72.8
Obesity, Overweight, and Weight Control				
Had obesity	16.0	16.4	21.6	23.4
Were overweight	17.4	18.2	15.9	19.2
Described themselves as slightly or very overweight	32.3	33.8	36.0	41.0
Other Health Topics				
Never saw a dentist	7.9	6.2	--	5.2
Reported that their mental health was most of the time or always not good	--	--	--	31.9
Did not get 8 or more hours of sleep	71.9	77.2	76.4	81.7

-- indicates No Data

Data Source: Centers for Disease Control and Prevention, High School YRBS, Northern Mariana Islands

According to the 2021 results of Youth Risk Behavioral Survey (YRBS), adolescents in grades 9 through 12 who are obese increased from 21.6 to 23.4 percent in 2019 to 2021 respectively; similarly, adolescents who were **not** physically active at least 60 minutes per day on 5 or more days increased from 63.5 percent in 2019 to 71.8 percent in 2021. Additionally, an increase is noted in the percentage of high school teens reporting suicidal ideation, with almost 30 percent of high school student in the CNMI reporting seriously considered attempting suicide in 2021. While the CNMI is reporting a decrease in cigarette use among high school students, the number of teens currently using and daily use of electronic vapor products, or e-cigarettes, is on the rise. According to the 2021 CNMI YRBS, more than half (56.1 percent) of high school students

have tried electronic vapor products, more than a quarter (26.4 percent) reported current use, and 7.8 percent reported daily use.

Children with Special Health Care Needs (CSHCN)

According to the MCH-JS, the CNMI has an estimated 8 percent of children ages 0 through 17 years who met the criteria for having a special health care need based on the CSHCN screener. Data gathered from the MCH Jurisdictional Survey indicated that only 13 percent of CNMI CSHCN, ages 0 through 17 reported having a medical home, significantly lower than the US percentage of 42.0 percent[1]. Additionally, only a little half (51%) of CNMI CSHCN reported receiving services necessary for transition into adult healthcare.

Title V Program Capacity Updates & Changes

In the spring of 2021, the MCHB was restructured to include the Immunization and WIC programs and renamed into the Maternal, Infant, Child and Adolescent Health (MICAH) Programs. The Title V Block Grant is administered through the CHCC MICAH Programs. The MCH Program is one of the seven programs under the MICAH, along with Family Planning, Universal Newborn Hearing Screening/Early Hearing Detection and Intervention Programs, H.O.M.E. Visiting, WIC, Immunization and Vaccines for Children (VFC), Family to Family Health Information Center, PRAMS and State System Development Initiative. In December of 2022, the MICAH Programs Administrator, who serves as the Title V Block Grant Project Director, was promoted to the role of Director of Population Health Services. In January of 2023, the former Fiscal Specialist is now serving as the MICAH Programs Administrator.

In April of 2022, the Child Health Coordinator, who also served as the CSHCN Project Director, resigned from the position. After the departure of the Child Health Coordinator/CSHCN Project Director, the MICAH programs unit began the process to realign the unit structure and restructure staff positions to more effectively address the needs of the community based on the priorities and strategies identified through the needs assessment process. The realignment and restructuring was completed on April 2023. Mrs. Shiella Deray has is now serving as the CSHCN Project Director.

In FY 2023, the Division of Public Health underwent a subsequent restructuring as part of efforts to strengthen the CNMI's Public Health foundational capabilities in alignment with the Foundational Public Health Services (FPHS) framework. The Immunization program was re-organized into the Communicable Disease Programs section and two new Public Health sections were established: 1) Data, Surveillance, and Performance Management; and 2) Health Promotions & Partnerships. The State Systems Development Initiative (SSDI) and the Pregnancy Risk Assessment Monitoring System (PRAMS) were restructured into the Data, Surveillance, and Performance Management section under Public Health.

As part of the re-organization, the Division will work to update its vision and mission statements, and strategic plan to align with the re-organization. This work is being conducted in FY2024 through support from the Association of State & Territorial Health Officials (ASTHO).

Partnerships, Collaboration, and Coordination

Perhaps one of the most significant partnerships the MICAH programs works diligently to maintain and strengthen are the partnerships with the clinical providers who serve the CNMI MCH populations. Chairpersons for the Women's and Children's Clinics at the CHCC health system are critical collaborators for advocating and championing many of the priorities and strategies that are intended to improve the health and wellness outcomes of CNMI women, children, and their families. The Medical Director for Public Health and the Family Planning Medical Director also play critical roles in the various activities and strategies identified in the CNMI MCH Title V, providing input and guidance on strategies.

The CNMI Public School System continues to be a major partner for strategies and activities targeting children ages zero through 17 years. The PSS Early Intervention Services Program and the Early Head Start program serve children from birth

through 3 years. PSS serves children ages 3 through 5 years in Head Start programs and children ages 6 through 17 years are enrolled in PSS K through 12th grade programs. The CHCC has formal MOUs with the PSS to collaborate on programs serving children enrolled throughout the system. CHCC population health programs collaborate with PSS to offer training/capacity building, school based screening services (such as STD/HIV and diabetes or hypertension), as well as other sexual and reproductive health services, such as counseling and access to contraceptives to prevent teen pregnancies and STD transmission. Other initiatives that CHCC has partnered with PSS are: Developmental Screenings, Bullying Prevention, Teen Pregnancy Reduction, Improving Immunization rates, Nutrition, and Physical Activity.

The Child Care Development Fund (CCDF), a program serving low-income families through childcare subsidies, is an additional key partner in the MCH program's work for serving children and families. MCH continues to partner with CCDF in the CNMI wide implementation of standardized developmental screening and in implementing the Quality Rating Improvement System (QRIS), which is focused on refining and improving the standards of quality for early care and education programs in the CNMI.

The MCH and WIC Programs have worked collaboratively for many years to improve breastfeeding rates, lower childhood obesity rates, and increase access to prenatal care.

The MCH partnership with the Northern Marianas College (NMC) Expanded Food Nutrition and Education Program (EFNEP) is focused nutrition and addressing obesity related activities among the MCH population. Additionally, nursing students through the NMC Nursing Program conduct clinical rotations in the Immunization clinic during the Fall and Spring semesters each year.

The Disability Network Partners (DNP) consists of programs that provide services to individuals with special healthcare needs and their families. The Northern Marianas College's University Centers of Excellence in Developmental Disabilities (UCEDD), CNMI Office of Vocational Rehabilitation, and Developmental Disabilities Council comprise the CNMI Tri-Agency partners who lead the overall DNP. Other partners involved in the DNP include the Northern Marianas Protection and Advocacy Systems Inc. (NMPASI), Public School System Special Education Program (SPED), Center for Living Independently (CLI), and the MICAH Programs. The DNP meets on a quarterly basis and works on projects such as the CNMI Disability Resource Directory, and the Annual Transition Conferences. Additionally, the CNMI MCH Title V Project Director serves as a council member on the Governor appointed CNMI Developmental Disabilities Council.

The CNMI Department of Public Safety and the Division of Fire and Emergency Services are also key partners in promoting the health and safety of the MCH population. MCH partners with the Department of Public Safety on child passenger safety initiatives, which include workforce capacity building that enable child passenger safety technician certification for MCH and CHCC nursing staff.

Internal partnerships across CHCC population health programs helps to strengthen the MCH system in the CNMI. MCH works closely with the Immunization Program in increasing community awareness on the importance of vaccines and in increasing access to immunizations through collaborations on community outreach events. Collaboration with the Breast and Cervical Cancer Screening Program positively contributes in the MCH program's efforts for increasing preventive screening rates among women in the CNMI. Other collaborative efforts include Diabetes, Cancer, Tobacco Control and other chronic disease prevention and health promotion.

The program coordinates with the Health & Vital Statistics Office, CHCC HIT Dept., and CHCC Medical Records Department on initiatives involving access and improving quality of population-based data.

Operationalization of 5-Year Needs Assessment

MICAH Programs staff work to evaluate and revise strategies and activities based on outcomes. Staff work collaboratively across programs and with partners to meet short- and long-term outcomes to support improvements in national and state performance measures that eventually impact the Title V national outcome measures.

5-Year Plan Changes for 2021-2025 (FY 2023)

No changes to Title V priority selections or strategies were made in FY2023.

Health Equity & Social Determinants of Health

The MICAH programs worked to integrate activities within the Title V MCH work plan for FY 2023 to address social determinants of health in strategies across population health domains as an approach for addressing health equity in the CNMI. Integrating screening for social determinants of health and implementing referral mechanisms were included as part of strategies to address priorities.

Changes in Organizational Structure and Leadership

In FY2023, Ms. Halina Palacios was appointed as Chief Operations Officer for Population for the CHCC. The Division of Public Health, which administers the MCH Title V Block grant, is unit within CHCC Population Health, co-located with the Community Guidance Center, which functions as the CNMI state mental health agency, and the CHCC Outpatient clinics.

Emerging Public Health Issues

The end of the US federal COVID-19 Public Health Emergency (PHE) was on May 11, 2023 in addition to the World Health Organization (WHO) declaring the end of the Global Pandemic in the same month. Multiple factors contributed to the end of both the PHE and the Global Pandemic, including population immunity, access to therapeutics and treatment, and a downward trend in infections and deaths. For very many in the CNMI, the end of the PHE also means and end to Medicaid coverage. In FY2022, the CNMI had approximately 24,000 (51%)[2] community members enrolled under the Medicaid Presumptive Eligibility coverage, which ended with the PHE. The loss of Medicaid coverage for thousands in the CNMI is continued to be an emerging public health issue with the potential to negatively impact access to primary and preventive care for the CNMI population, including the MCH populations.

[1] The Child & Adolescent Health Measurement Initiative. (ND). 2020-2021 National Survey of Children's Health. Retrieved on July 14, 2023 from https://www.childhealthdata.org/browse/survey/results?q=8569&r=1

[2] Commonwealth Medicaid Agency. (2022). 2022 Citizen-Centric Report Commonwealth Medicaid Agency (CMA) Office of the Governor. Accessed on July 14, 2023 from https://cnmileg.net/resources/files/2022%20CENTRIC%20REPORT/Medicaid%20CCR22.pdf

Click on the links below to view the previous years' needs assessment narrative content:

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$465,091	$466,540	$466,540	$473,287
State Funds	$0	$0	$0	$0
Local Funds	$0	$0	$0	$0
Other Funds	$475,634	$512,582	$487,995	$465,967
Program Funds	$0	$0	$0	$0
SubTotal	$940,725	$979,122	$954,535	$939,254
Other Federal Funds	$2,660,090	$6,730,842	$10,877,895	$5,162,601
Total	$3,600,815	$7,709,964	$11,832,430	$6,101,855

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$466,540	$489,239	$474,000	
State Funds	$0	$0	$0	
Local Funds	$0	$0	$0	
Other Funds	$479,204	$463,932	$459,410	
Program Funds	$0	$0	$0	
SubTotal	$945,744	$953,171	$933,410	
Other Federal Funds	$7,930,007	$8,902,682	$7,401,082	
Total	$8,875,751	$9,855,853	$8,334,492	

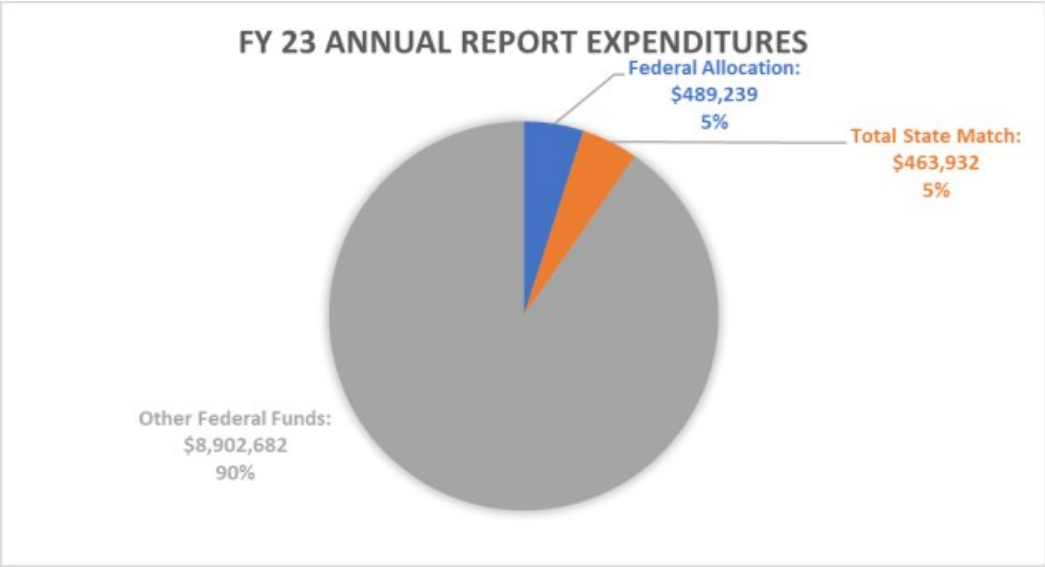
	2025	
	Budgeted	Expended
Federal Allocation	$490,000	
State Funds	$0	
Local Funds	$0	
Other Funds	$417,385	
Program Funds	$0	
SubTotal	$907,385	
Other Federal Funds	$8,599,630	
Total	$9,507,015	

III.D.1. Expenditures

Overview of Expenditures:

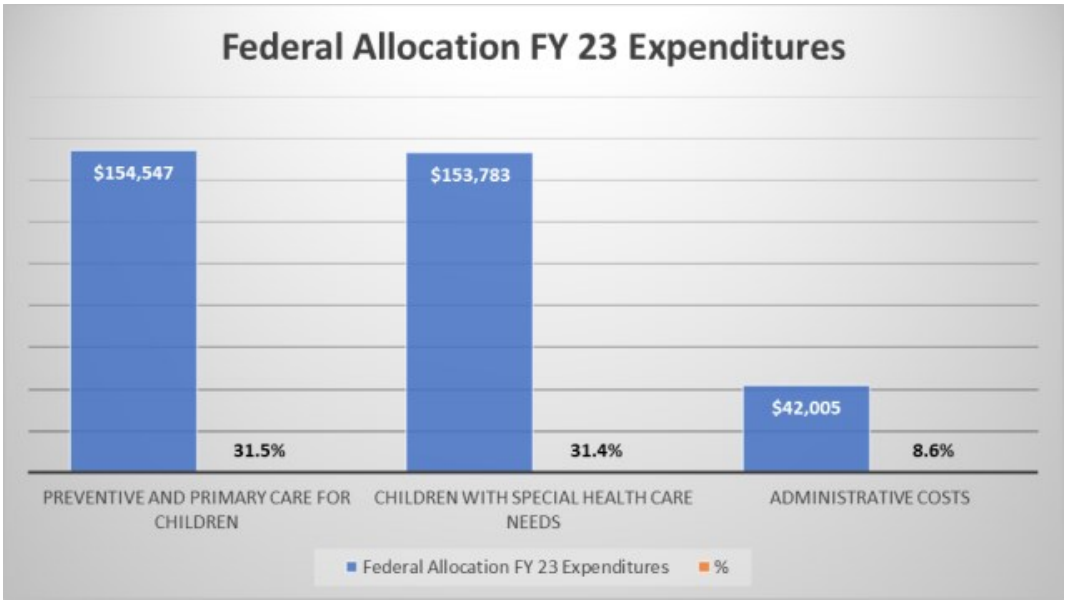
The mission of the CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships. The MICAH Programs works towards achieving this overarching work through the Commonwealth Healthcare Corporation (CHCC) and with its internal and external partnerships.

Below is a chart that displays the CNMI FY 23 Expenditures:



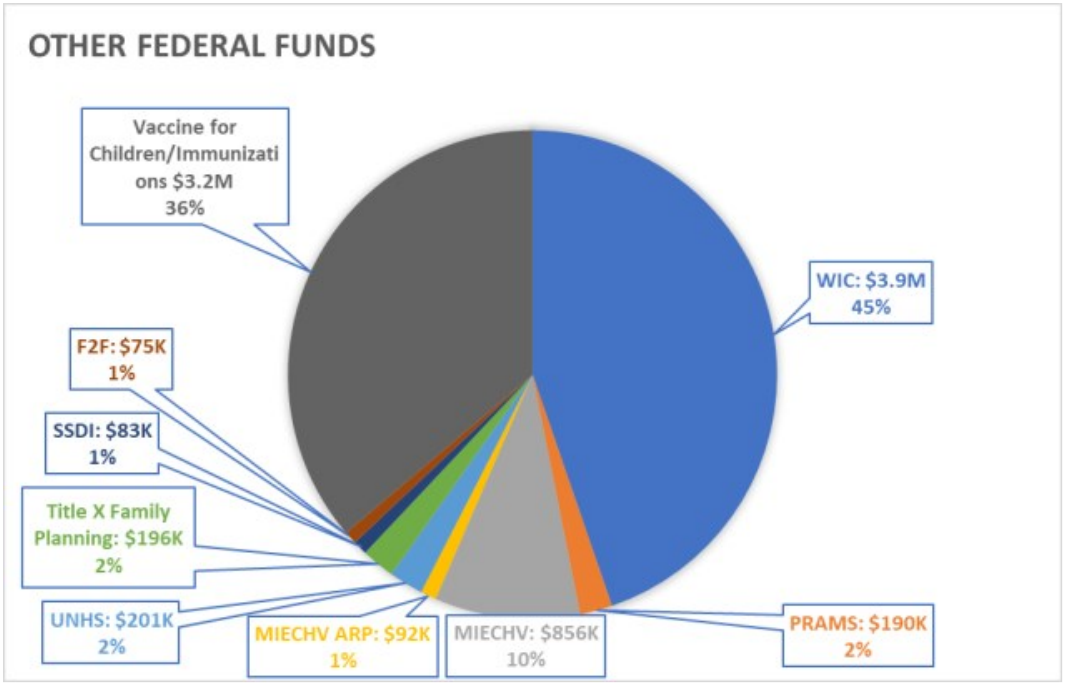
Legislative Requirements Met:

The CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. The MICAH Programs Administrator conducts monthly fund status report that consist of current funds available, funds encumbered, funds expended and the legislative required 30-30-10 percentage status report. The MICAH Programs Administrator develops the Title V Block Grant Budget and continuously monitor and track expenditures to ensure compliance with the legislative financial requirements. Expenses are monitored and tracked through the state's accounting system called the, *Tyler Munis (Enterprise ERP) and JD Edwards*. The Title V legislation requires a minimum of 30% of the block grant funds to be utilized for preventive and primary care for children and a minimum of 30% of the block grant funds for services for CSHCN. In addition, no more than 10% of the grant may be used for administration costs. The CNMI MCH Program has met the required legislative percentages for FY 23. The chart below provides an overview of the required federal allocation for the FY 23 expenditures.



Other Federal Funds:

The chart below provides an overview of the Other Federal Funds expended that were under the direct authority of the MICAH Administrator which are also listed in Form 2 [Pregnancy Risk Assessment Monitoring System (PRAMS), Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, MIECHV American Rescue Plan(ARP), Universal Newborn Hearing Screening and Intervention Program (UNHS), Title X Family Planning, Women, Infants and Children (WIC), State Systems Development Initiative (SSDI), Family Professional Partnership/CSHCN (F2F), and the Vaccines for Children/Immunizations]. The Other Federal Funds total expenditure is $8,902,682.



Total State Match:

The Total State Matching funds in the amount of $463,932 was expended for FY 2023. The majority of the total Other Funds/Total State Match were expended towards personnel salaries for staff at the Commonwealth Healthcare Corporation that provides direct services to the MCH population. Since the Other Funds/Total State Match contribute to direct services, majority of the Title V funds contribute to enabling services and public health services and systems. The actual total amount of in-kind support provided by the CHCC to the maternal and child health population continue to exceed the amount reported on the Title V MCH program expenditures. However, the Title V MCH program will only report budgeted salary percentages that were stated on the proposed non-federal budget.

III.D.2. Budget

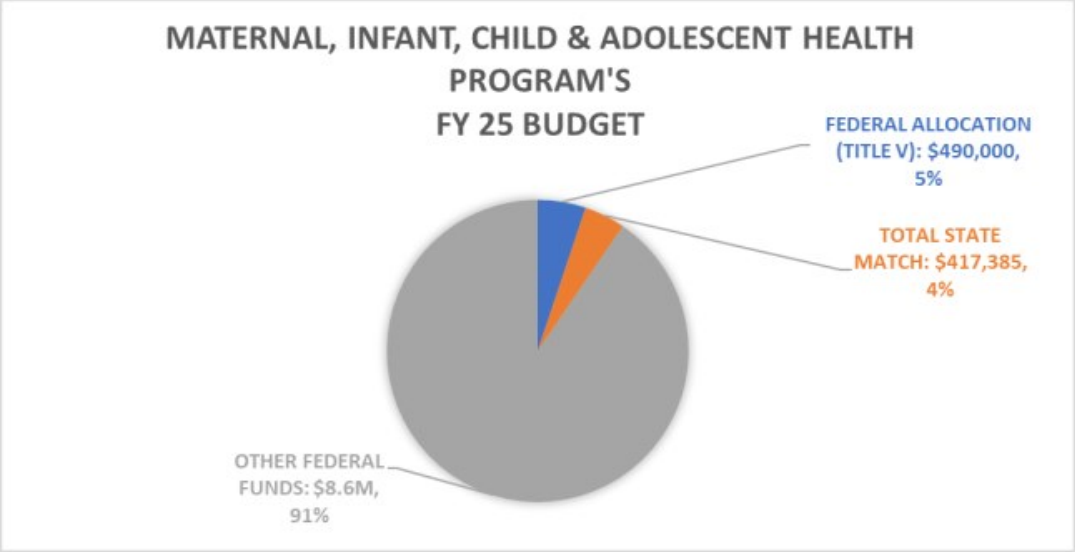
Budget Overview:

The mission of the CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs under the Commonwealth Healthcare Corporation is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships. The MICAH Programs works towards achieving this overarching work through the Commonwealth Healthcare Corporation (CHCC) with its internal and external partnerships; and in FY 2025 estimating a total state MICAH Programs budget of $9M.

The MCH Program's State Action Work Plan has been developed based on the Needs Assessment and current emerging issues. Therefore, the MCH Program's State Action Work Plan determines where the MCH federal grant dollars are budgeted. The MCH grant, all Other Federal Funds under the MICAH Programs, and the Total State Match continues to align its overarching goals and objectives to effectively leverage resources to serve the MICAH population. The Title V funds consist of personnel salaries and fringe benefits that support the following staffing: MICAH Programs Administrator, MICAH Program Manager (Service Coordination) and 3 Community Health Outreach Workers (CHOW) I. In addition, the MCH Program cost shares with other federal program funds to support the following staffing: Adolescent & Reproductive Health Program Manager, Health Promotion Specialist, 1 CHOW I, and the MICAH Administrative Specialist. The Title V funds also support 50% of the Public Health Services Director's FTE who serves as the Project Director for the MCH Title V Block Grant. The Adolescent & Reproductive Health Program Manager is funded 27% under the Title V funds and 73% under the Family Planning Program funds. The Health Promotion Specialist is funded 20% under the Title V funds and 80% under the Immunization and VFC Program funds. The CHOW I is funded 50% under the Title V funds and 50% under the Family Professional Partnership/CSHCN funds. The MICAH Administrative Specialist is funded 50% under the Title V funds and 50% under the ACA Maternal, Infant Early Childhood Home Visiting funds.

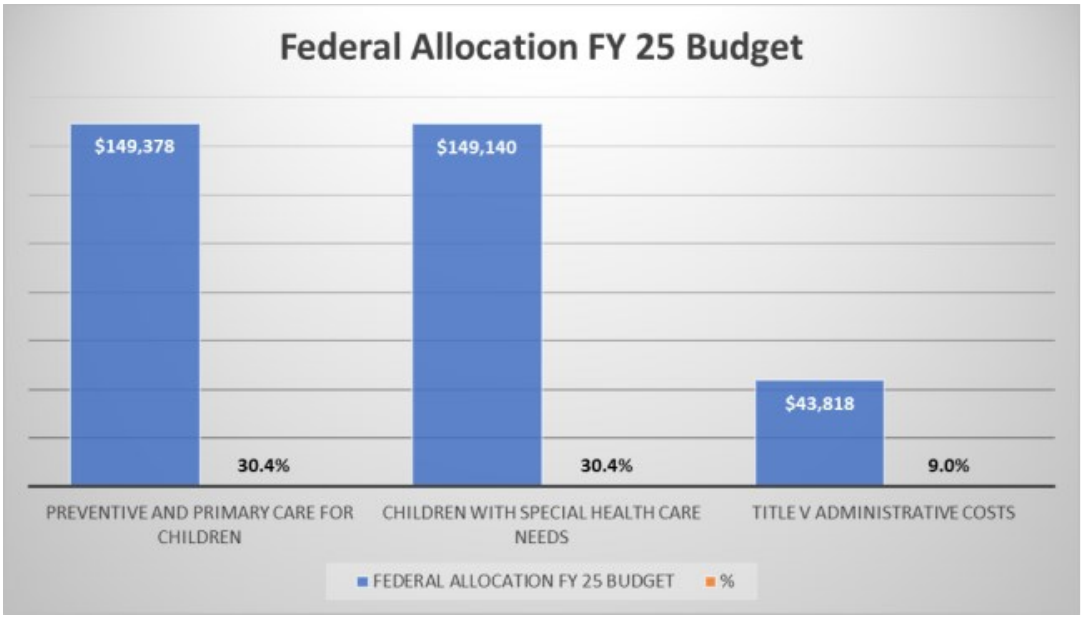
In addition to personnel salaries and fringe benefits, the Title V funds are budgeted towards Public Education and Awareness, Supplies and All Other Costs to support the MCH Programs activities and initiatives stated on the State Action Work Plan. For instance, public education and awareness costs include print, radio, local newspapers, television and social media posts on the importance of preventive screenings, annual preventive visits and prenatal care. Community awareness includes publicizing available services and programs such as, home visiting and other available health services that cater to the MCH population. The MCH Program will continue to educate the community on the importance of preventive screenings among infants, children, adolescents and women populations. Title V funds will be utilized towards family support materials for prenatal care programs, adolescent focused activities, Women's Health Month, breastfeeding support supplies and other community outreach events that serve the MCH population. Title V funds will be utilized to support the costs of newborn bloodspots and metabolic screenings and newborn screening kits, shipping of specimens for testing, and access for preventive visits for children and pregnant women. Funds are also utilized towards other costs such as travel, dues and subscriptions, license and fees, repairs and maintenance, communication services costs, office space rental, and et cetera.

The chart below provides an overview of the CNMI MICAH's FY 2025 Budget as reported on Form 2.



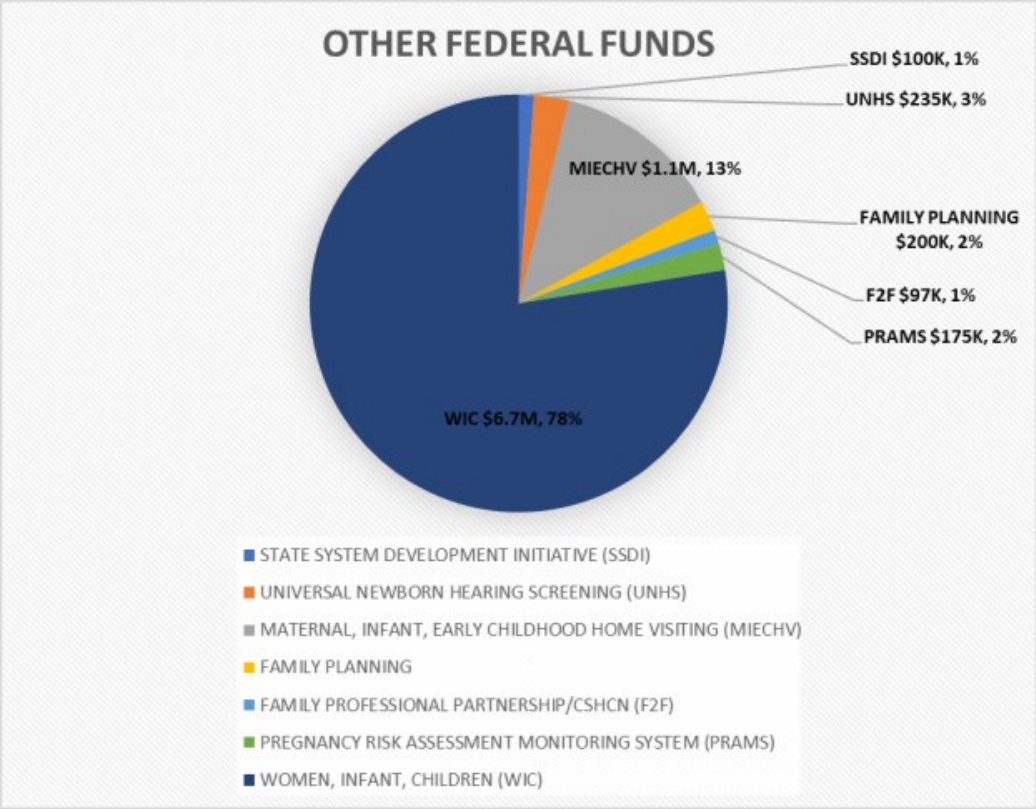
Legislative Requirements Met:

The CNMI MICAH Programs is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. One of the main duties and responsibilities of the MICAH Programs Administrator duties is to continuously ensure that the funds are being budgeted and expended per the minimum required 30-30-10 percentage. The Fiscal Year 2025 Title V Block Grant estimated budget proposal of $490,000 consist of the following types of individuals served: Pregnant Women and Infants less than 1 year of age was budgeted at $124,561 which is at 25% of the total federal award. Preventive and Primary Care for Children was budgeted at $149,378 which is at 30% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Children with Special Health Care Needs was budgeted at $149,140 which is 30% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Administrative costs budgeted at $43,818 which is 9% of the total direct costs of the federal grant award. A total of $23,104 was budgeted for All Other Costs such as dues and subscriptions, license and fees, repairs and maintenance, office space rental, utilities and cleaning services. The chart below provides a budget overview of the required federal allocation for the FY 25 Budget.



Other Federal Funds:

The chart below provides an overview of the Other Federal Funds budgeted that are under the direct authority of the MICAH Programs Administrator which are also listed in Form 2 [State Systems Development Initiative (SSDI), Universal Newborn Hearing Screening and Intervention Program (UNHS), Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, Title X Family Planning, Family Professional Partnership/CSHCN (F2F), Pregnancy Risk Assessment Monitoring System (PRAMS) & Women, Infant & Children (WIC)].



The Other Federal Funds under the control of the MICAH Programs Administrator is responsible for the administration of the Title V program budgeted for the estimated amount of $8,599,630.

Total State Match:

The MCH match is budgeted at $417,385 which is comprised of the Commonwealth Healthcare Corporation in-kind funds which will comply with the required FY1989 Maintenance of Effort amount. Therefore, the Federal-State Title V Block Grant Partnership subtotal is $907,385. The Total State Match funds are budgeted towards personnel salaries and fringe benefits for staff at the Commonwealth Healthcare Corporation that provides direct services to the MCH population. Since the State Match funds contribute to direct services, majority of the Title V funds contribute to enabling services and public health services and systems.

III.E. Five-Year State Action Plan

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

State: Northern Mariana Islands

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

The mission of the CNMI MCH Title V Program is *"To promote and improve the health and wellness of women, infants, children, including children with special healthcare needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships."* Title V funds are administered through the Division of Public Health Services unit under the Commonwealth Healthcare Corporation (CHCC).

The CHCC Maternal and Child Health Bureau was formed in 2014 to address the needs of the CNMI MCH population, transformation of the MCH Title V Block Grant, and link all opportunities between MCH programs to work through challenges common across programs since the transition of the Corporation into a semi-autonomous agency. Since then, the CHCC has gone through re-organization and in 2021, the MCHB was restructured under the CHCC Division of Public Health Services (PHS) unit into the Maternal, Infant, Child and Adolescent Health (MICAH) Programs section, with WIC and Immunization services integrated within the unit. In FY 2023, the Division of Public Health underwent a subsequent restructuring as part of efforts to strengthen the CNMI's Public Health foundational capabilities in alignment with the Foundational Public Health Services (FPHS) framework. The Immunization program was re-organized into the Communicable Disease Programs section and two new Public Health sections were established: 1) Data, Surveillance, and Performance Management; and 2) Health Promotions & Partnerships.

As part of the re-organization, the Division will work to update its vision and mission statements, and strategic plan to align with the re-organization. This work is being conducted in FY2024 through support from the Association of State & Territorial Health Officials (ASTHO).

The CHCC is the only health department in the CNMI and provides all public health services, including direct, enabling and infrastructure building to all islands within the territory.
The CHCC Public Health Services unit is comprised of 6 sections:

- Maternal, Infant, Child & Adolescent Health (MICAH) Programs
- Non-Communicable Disease Programs
- Communicable Disease Program
- Environmental Health & Disease Prevention (EHDP)
- Data, Surveillance, and Performance Management
- Health Promotions & Partnerships

Each of these sections include several programs and provide services for the entire CNMI population. The MICAH Programs section is comprised of the following programs:

- Adolescent & Reproductive Health
- WIC Program
- Children with Special Health Care Needs (CSHCN)
- Home Visiting
- MCH Program

The State Systems Development Initiative (SSDI) and the Pregnancy Risk Assessment Monitoring System (PRAMS) were restructured into the Data, Surveillance, and Performance Management section under Public Health.

Beginning in the latter part of 2019, the CHCC initiated efforts for a health system redesign in which a clinical integration approach for impacting population health was adopted. Activities as part of this effort experienced some delay as a result of prioritization of COVID-19 response. However, as health department activities transitioned out of pandemic response, focus was redirected towards initiatives to further integrated care efforts. This approach to care considers a wide range of

influences and interrelated conditions that impact the health of populations over the life course, identifies systematic disparities in their patterns of occurrence, and applies the resulting understanding to improve the health and well-being of those in our population. This strategy also is intended to shift the focus of a coordinated public health- clinical partnership to prevention, multiple determinants of health, equity in health, cross-systems action and partnerships, and understanding the needs and solutions necessary through community outreach. MICAH programs, and MCH Title V Program, contributes population based and enabling services, supported by evidence, into this clinical integration implementation.

Strategies identified within the CNMI MCH Title V State Action Plan are designed to: 1) improve access to comprehensive primary and preventive healthcare; 2) provide health promotion to reduce the incidence of preventable diseases, morbidities, and mortalities; 3) reduce barriers and increase access to preventive, screening, and treatment services; 4) improve coordination across programs that serve MCH populations.

In addition, the MCH Title V program is responsible for:

- Action plan development for each priority identified for each MCH population domain.
- Monthly progress reports on each priority for each MCH target population group.
- Monthly MCH Team meetings and learning sessions for review of priority progress to identify barriers, successes, and opportunities for collaboration.
- Ongoing quality improvements, such as partnership building, community engagement, resource allocation, and meeting effectiveness.
- Evaluation of the performance management and quality improvement infrastructure resulting in the revision and expansion of program processes.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

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

Staffing Structure

The CNMI MCH workforce is primarily housed within the CHCC and spread across clinical and population health programs, primarily under the MICAH programs unit. Approximately 125 employees make up the Public Health Services (PHS) section, of which 40 are stationed in the MICAH unit.

A consolidation of MCH serving programs was done in 2014 to address the needs of the CNMI MCH population, transformation of the MCH Title V Block Grant, and link all opportunities between MCH programs to work through challenges common across programs since the transition of the Corporation into a semi-autonomous agency. While most of the staff are funded by sources other than Title V, all contribute to the Title V mission and MCH priorities. For example, many MICAH staff work within the Healthy Outcomes for Maternal and Early Childhood Visiting Program, implementing the CNMI HOME visiting plan. In 2021, the MICAH went through another reorganization with Immunization and WIC programs integrated within the unit. Subsequent to this, a restructuring of the entire Division of Public Health Services was conducted in 2023, in which the Immunization Program was transitioned out of the MICAH programs section into the Communicable Disease Programs section. Similarly, the SSDI project and PRAMS were transitioned into the Data, Surveillance, and Performance Management section.

While the MCH program is working closely with the CHCC administration to improve current workforce capacity, the capacity to effectively meet the varying needs of the maternal and child population in the CNMI might be challenged by the limited number of professionals working directly for the MCH program. The consolidation of programs into a single unit was meant to align priorities for all programs that serve the maternal and child populations in the CNMI. However, each program under MICAH is responsible for administering a separate federal grant that includes individual program reporting requirements and project objectives.

In efforts to strengthen the alignment of priorities that serve the maternal and child populations, the MICAH Programs Administrator and the Public Health Services Director engaged in the planning and development of the restructure and reorganization of current staffing. Gaps identified in the current MICAH staffing structure have been addressed through a process that includes the blending of funding sources to be able to more effectively address MCH population priorities. Under this proposed structure, position descriptions were developed based on community priorities as opposed to individual grant requirements. Where feasible, blending of programmatic grant allowed for programs under the MICAH section to maximize staff capacity while meeting the overall community needs.

Recruitment & Retention

Recruitment of staff is handled through the CHCC Human Resource office and coordinated in accordance with CHCC Human Resource policies and procedures. The CNMI as a whole experiences difficulty in workforce recruitment as the shortage in local skilled workforce has forced organizations, both public and private, to recruit from other countries through a CNMI only workforce permit that is scheduled to phase out by 2029. Nursing positions are the most difficult to fill due to a national workforce shortage in the field. The CNMI, like many US states and other jurisdictions and territories, recruits a large majority of its nursing workforce from the Philippines. However, due to annual reduction in available CNMI conditional worker permits until the program eventually phases out in 2029, the CNMI faces increasing challenges in recruiting and retaining nurses. Various industries compete for these limited number of permits and as such the healthcare field, and CHCC in particular, competes with both public and private

agencies across the CNMI. The CNMI also faces challenges in recruiting medical providers. Due to CMS Conditions for Participation, CNMI regulations require that medical providers be US trained or US board certified in order to be licensed providers in the CNMI and this has limited recruitment to the US mainland. The CNMI's geographic location and distance from the US mainland poses a challenge for recruiting medical providers and turnover is high.

Staffing for the public health programs, including the Title V MCH Program, is largely made up of a local workforce. The MICAH Programs Administrator, Services Coordinator, and SSDI Project Coordinator, for example, are local to the CNMI. Because of limited opportunity for post-secondary education locally, many community members move off-island to attend colleges and universities in the US mainland. While some eventually return to the CNMI, many do not return for various reasons.

The CHCC has been working diligently in implementing strategies to support workforce retention. Standardization and updating of employee classification scales, recruitment tools such as pre-employment skills assessments, and a focus on performance improvement and professional development are key advances. To support these efforts, the CHCC has expanded its HR team to include a Recruitment Manager and Retention Manager. Other strategies employed by the CHCC includes loan repayment for certain fields, such as pharmacists, physicians, mid-level providers and licensed behavioral health workers through funding made available through US Health Resources and Services Administration (HRSA).

Training

Staff within PHS have varied professional experiences, training and very few have any formal education or training in public health. Most staff have obtained training in public health and related topics through employment at the CHCC and through participation in conferences and training opportunities supported by federal funds awarded to CHCC Public Health Services or by attending webinars and virtual learning opportunities made available through federal partners such as HRSA, CDC, and OPA.

The CHCC MICAH is working closely with the CHCC Professional and Organization Development (POD) office on coordinating training needs for both MICAH staff and personnel across the health department who work MCH target groups. The CHCC's strategy is to provide comprehensive and holistic community health services, including medical, dental, mental health and substance abuse screening perinatal, nutrition, and family planning, all supplemented by enabling services including outreach, case management, and transportation. Other strategies are: 1) work with schools to ensure that all children enrolled are up to date with their immunization; 2) collaborate and partner with other agencies, both private and governmental, during island-wide community events which will strongly emphasize lifestyle behavioral changes especially with health care practices, diet, and physical fitness; 3) establish a network linkage with other providers to inform them of health news, health alerts, awareness events, training, etc.; 4) develop partnership with other agencies to ensure continuity of care. Staff are given the opportunity to attend trainings provided by internal partners, such as the Non-Communicable Disease Unit's Diabetes' Management training. The established partnership with other agencies has also provided numerous training opportunities for the staff.

Web-based training opportunities provide an ideal training format for MCH staff in the CNMI, especially since many technical assistance and training needs are not easily met by local capacity. However, while virtual learning sessions provide the MCH workforce in the CNMI the opportunity to interact with experts and other technical assistance that are not readily available on island, the time difference between the CNMI and the US mainland makes it challenging

for staff to participate as often times sessions are held early mornings, in some cases 3 AM CNMI time.

The need to build and improve the workforce for sustainability of the public health programs is imperative to improving delivery of services to the community. The CHCC administration is focused on developing competent, committed and compassionate MCH professionals. The CHCC works closely with the Northern Marianas College school of Nursing and has a robust clinical rotation partnership for nursing students to gain training through clinical rotations throughout the health system.

Additionally, CHCC Public Health Services coordinate training offerings to CNMI health system staff, both clinical and non-clinical, and partner agencies on topics related to improving maternal and child health, such as:

- Lactation/Breastfeeding Training
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Motivational Interviewing
- Infant and Child Oral Health (Fluoride Varnish and Silver Diamine Fluoride) Training
- Routine Childhood Vaccination Administration
- Vaccine storage and handling
- Contraceptive Counseling
- Ages & Stages Questionnaire, 3rd Edition, Developmental Screening Training
- Infant Safe Sleep
- Human Subjects Training
- Brief Tobacco Intervention
- Pacific Cancer Project ECHO and Telehealth Sessions
- Sexual and Reproductive Health

Partnerships with the following agencies enable these training opportunities to be coordinated for the MCH workforce in the CNMI:

- Reproductive Health National Training Center (RHNTC)
- Centers for Disease Control & Prevention Immunization Services Division
- Centers for Disease Control & Prevention Division of Reproductive Health
- Association of Maternal & Child Health Programs (AMCHP)
- Association of State & Territorial Health Officials (ASTHO)
- Association of Immunization Managers (AIM)
- Pacific Islands Health Officers Association (PIHOA)
- University of Hawaii at Manoa
- Substance Abuse & Mental Health Services Administration (SAMHSA)

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

The MCH Program continues to work collaboratively with both internal and external programs, which allows involvement of families at all levels, individually, and at the decision-making level. Family/consumer engagement has taken place through advisory committees, strategic and program planning, quality improvement, workforce development, block grant development and review, materials development, and advocacy.

In order to ensure that services are effectively meeting the needs of the local population, programs under MICAH have taken a collective approach towards involving families in programmatic decision-making. A significant amount of family engagement activities is coordinated through the Family-to-Family Health Information Center (F2F HIC), a unit within the MICAH CYSHCN Program. Since the implementation of the F2F HIC in the CNMI in 2019, through funds provided by HRSA and MCH Title V funding, there has been increased activity around building parent, caregiver, and family capacity around advocacy and empowerment. These were facilitated through informative learning sessions, recruitment of parent leaders to provide peer support, parent leadership training, establishing support groups and providing opportunities to attend national conferences. There have been increase in family participation partnership meetings, community awareness activities and promotion of primary care and preventive services. Additionally, there family leaders participate in conducting survey data collection, in which information is used to inform activities and CNMI MCH programming.

Strategies used to engage families in MCH activities in FY 2023 include:

- Continue to fund three (3) full time Community Health Workers (CHWs) the provide service coordination on Saipan, Tinian, and Rota.
- Continue to fund one (1) CHW stationed at Children's Clinic to conduct ASQ 3 developmental screenings and hearing screenings until 3 years of age and coordinate referrals from the pediatrics department to Early Intervention Services or SPED.
- Providing stipends/vouchers to parent leaders who participate in family engagement activities, provide peer support, translation services, and other related activities.
- Coordinated family engagement classes that promoted health and nutrition and other communication modality (such as basic ASL).
- Providing transportation assistance to families to meet their appointment needs at clinic, Early Intervention, Medicaid office and other partner agencies.
- F2F HIC parent leaders are promoting MICAH Programs by leading the program and services exhibits at community events.
- Providing one-to-one Peer-to-Peer support to families with ASD, Down Syndrome and DHH children.
- Engaging CNMI families to participate in social media posts, brochures and other printed informational brochures and materials.
- Offering flexibility in meeting hours to meet family availability (evening or weekends).

In 2023, the F2F HIC offered 5 learning sessions from November 2022 - September 2023 (*Table 1, below*). The sessions were attended by 168 individuals representing families and professionals in the CNMI. Feedback from presenters, parents, and CYSHCN serving professionals who attended these sessions indicated the sessions were helpful in sharing information and improving engagement between families and professionals who serve CSHCN. The F2F HIC is working to increase learning sessions and expand the range of topics offered to further build capacity among CSHCN families and professionals who serve CSHCN.

Figure 1: F2F Learning Sessions offered in 10/2022-09/2023

Month	Topic	Trainer/Facilitator	Participants
November 2022	Centers for Living Independently (CLI)	Susan Satur, Program Director	17
February 2023	Parent Education Services	Maria Olopai, Community Dev Specialist	41
April 2023	Understanding Functional Behavior & Sensory Processing	Jerry Diaz & Gina Aguillar	37
August 2023	CNMI University Center for Excellence in Developmental Disabilities Program	Eileen A. Babauta, Program Director of UCEDD	25
September 2023	Make Every Bite Count	NMC CREES - Ashley Sikayun	48

Data Source: CNMI F2F Health Information Center

Currently, there are eleven (11) active parent leaders and two (2) parents stationed on the island of Rota, who provide peer support, outreach, and translation services for families. These parent leaders spend roughly ten (10) hours per month each providing these services in partnership with the F2F HIC and sign an annual agreement with the CHCC MICAH. Their time and effort is compensated by the program.

Additionally, monthly support group meetings are facilitated by the CNMI F2F HIC for families with children diagnosed with autism spectrum disorder and another for families with children diagnosed with Down Syndrome. These monthly support group meetings are open to any family in the community seeking support or information about caring for their child. Also, parents in these support groups are heavily involved in planning the annual CNMI Autism Awareness Month and Down Syndrome Awareness Month. They have been taking the initiative to plan activities for the month such as family fun day, picnic by the beach, playdates at the park. For this reporting period, the CNMI F2F HIC facilitated ten (10) ASD peer-to-peer sessions, nine (9) Down Syndrome peer-to-peer sessions and one (1) DHH peer-to-peer session.

Support for transportation services is provided via gas or COTA transportation vouchers to help families access medical or related health appointments for their children. In 2023, 254 COTA vouchers were issued for access to the following offices and locations: WIC, Children's Clinic, Dental Clinic, TB Program, radiology, behavioral health services, food stamp office, and others. During this project year, there is focus on increasing public awareness regarding transportation assistance available via the MICAH CYSHCN program. Posters and flyers were created and distributed throughout the CHCC campus and shared with partner agencies and other stakeholders.

Related advisory committees that MICAH programs are involved in which include family partners as members include the: Interagency Coordinating Council (ICC), CSHCN stakeholder group, H.O.M.E. Visiting Community Advisory Board, EHDI Advisory Board, Disabilities Network Partners, Governor's Council on Developmental Disabilities, Pediatric Mental Healthcare Access Program Advisory Council, and the Head Start Advisory Council. Families and community members also take active roles in the planning and coordinating of annual CNMI wide events, give feedback on annual reports and applications, and contribute in identification of strategies.

In addition to these efforts, MCH consults with the national Family Voices and the Hands and Voices organization on strategizing ways to build self-advocacy and leadership capacity among parents and families who have children with disabilities.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The ability to use data relies heavily on having a workforce trained in epidemiology, data analysis, and data systems. In FY2023, the CHCC Division of Public Health Services underwent a re-organization as part of efforts to better integrate programs and services, leverage funding mechanisms, and to strengthen public health functions and foundational capabilities in the CNMI so that they are better aligned with the best practice standards published by the national Public Health Accreditation Board (PHAB). As a result, the Division established a new section focused on Data, Surveillance, and Performance Management where projects and staff members whose role is focused on public health data, surveillance, and performance management were transitioned. The State Systems Development Initiative (SSDI) and the Pregnancy Risk Assessment Monitoring System (PRAMS) projects were both transferred into this new division unit. Subsequent action steps as part of the restructuring include the following: 1) Recruitment and onboarding of an Administrator to oversee development, implementation and monitoring of the unit's operations and activities and 2) Development of a unit work plan, outlining action steps and deliverables.

As an initial project of this newly established unit, team members took part in a data workgroup in the spring of 2024 that spearheaded collection and analysis of data utilized as part of the 2024 CNMI Community Health Assessment (CHA) which will be used to inform the 2024 CNMI Community Health Improvement Plan (CHIP).

Through CDC funding that supports the CHCC Epidemiology Laboratory Capacity (ELC) program, the CHCC employs a full time epidemiologist, Ms. Jennifer Dudek who provides support to public health on data and surveillance activities, including supporting MCH epidemiology workforce.

An outline of staff members who contribute to data analysis and data systems for MCH include:

Epidemiologist: Jennifer Dudek, MPH. has 12+ years' experience in public health. Ms. Dudek has extensive data management and analysis background and has provided technical assistance and training in the epidemiologic capacity in tribal communities. Ms. Dudek is also skilled in designing, planning, and initiating epidemiologic studies, surveys, and investigations. Ms. Dudek has an MPH concentration in Epidemiology and a background in Microbiology. Her technical Skills include SAS, SPSS, ArcGIS, Epi info. The position is funded through the CHCC Epidemiology and Laboratory Capacity (ELC) program.

State Systems Development Initiative (SSDI) Project Coordinator: Richard Sablan, BS. The SSDI Project Coordinator position is funded through SSDI grant funding. Richard has a Bachelor's Degree in Public Health Education from California State University San Bernadino. In 2019, Richard completed the HRSA/MCHB National Training Course on MCH Epidemiology in Charleston, South Carolina. The training course focused on statistics and epidemiological methods. In 2024, Richard was selected to participate in the 2024 Training Course in Maternal & Child Health Epidemiology offered by the Maternal and Child Health Bureau (MCHB), Centers for Disease Control and Prevention (CDC), and CityMatCH. The training course is focused on Statistics and Epidemiological Methods as part of their ongoing efforts to improve the analytic capacity of state and local health agencies. Richard completed the training in June 2024.

Early Hearing Detection and Intervention (EHDI) Data System Administrator: Vacian Pangelinan. The EHDI Data System Administrator position is funded through a federal award from the HRSA MCHB UNHS program. Mr. Pangelinan completed college coursework through Riverside Community College in California and completed

certification in CompTIA A+. As the EHDI Data System Administrator, Vacian oversees the data linkages between the newborn hearing screening machines, EHDI database and the birth registry system out of the HVSO. Additionally, the EHDI Data System Administrator conducts data quality checks, generates hearing screening data reports, and works identify needed data system upgrades/updates. Mr. Pangelinan is cross trained in conducting newborn hearing screenings and often times provides technical support to hospital nursing staff when issues arise with the hearing screening equipment.

Immunization Information System (IIS) Coordinator: Cyji C. Tenorio. Mrs. Tenorio completed college coursework at Heald College in Honolulu, Hawaii. She has an education and career background in the healthcare field, with 13 years working at a private dental clinic practice. She joined the CNMI Immunization Program in February 2023, almost 9 months after the position was vacated. The IIS Coordinator position is supported through federal funding form the Centers for Disease Control and Prevention (CDC). The IIS Coordinator is responsible for facilitating activities and project plans related to the CNMI's implementation and utilization of the immunization registry, the Weblz. Mrs. Tenorio provides oversight of data staff, oversees the maintenance activities of the registry, monitors data quality, generates data reports and tabulations, and works with various federal, national, and regional partners such as the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), American Immunization Registry (AIRA), and others in reporting on vaccination coverage rates in the CNMI.

Home Visiting Data Specialist: Jerome Ballesteros AAS, graduated from the Northern Marianas College on the island of Saipan with an Associate of Applied Science Degree in Business with an emphasis in Computer Applications. The Home Visiting Project Data Specialist position is funded through the HRSA MIECHV grant award. Mr. Jerome Ballesteros has served as the Data Specialist since October 2017 and is responsible for maintaining the data collection systems and processed for the Home Visiting program. The position is responsible for monitoring and reviewing data collected as described under the Home Visiting data collections and conducts quality review checks and quality improvement projects to improve upon the program data collection processes and systems. Additionally, Mr. Ballesteros prepares summaries of statistical reports and other related MCH reports and tabulations.

Additionally, the CNMI CHCC has been able to leverage epidemiological support from the Pacific Islands Health Officers Associations (PIHOA). During the CNMI's COVID-19 surges, where large volumes of community transmission were occurring, the CNMI was able to leverage epidemiological support from the PIHOA regional communicable disease epidemiologist, Ms. Stephanie Kern-Allely. PIHOA also provides support in non-communicable disease epidemiology to the CNMI through regional epidemiologist Dr. Haley Cash.

In the fall of 2022, the CHCC Division of Public Health entered into a Memorandum of Understanding (MOU) with PIHOA to conduct the Post- Graduate Certificate in Field Epidemiology (PGCFE) program in the CNMI. The program is formerly known as the Data for Decision Making (DDM) and made possible through the PIHOA, CDC, and Fiji National University (FNU). The program is accredited through FNU and is modeled after the Centers for Disease Control and Prevention's Field Epidemiology Training Program. The training content has been modified to meet the needs of the Pacific to identify public health challenges within the region and transform factual data into action[i].

In January of 2023, the PGCFE program launched with a cohort of 12 health department staff members of which 3

are staffers from the MICAH unit. The CNMI's first cohort completed the program in September of 2023. Additionally, 6 participants from cohort 1 continued on to enroll in course work as part of a subsequent program, the Post Graduate Diploma in Applied Epidemiology (PGDAE).

Planning for a second cohort of the PGCFE is currently being conducted to provide training to other CHCC team members who did not get a chance to participate with the first cohort and allow those newly hired data staff members to gain training. It is projected that the second cohort will launch in FY2024.

Photo: 2023 CNMI PGCFE Training Participants with instructors, CNMI Health Official, and Director of Public Health Services.

[i] Saipan Tribune. (2023). CHCC launches field epidemiology certificate program. Retrieved on July 16, 2023 from https://www.saipantribune.com/index.php/chcc-launches-field-epidemiology-certificate-program/

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The State Systems Development Initiative (SSDI) project continues to expand data capacity by collecting analyzing and using reliable data for the CNMI Title V MCH Block Grant program. The SSDI Project leads data collection and analysis efforts for MCH needs assessment, National Outcomes Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs) and Evidence-based or Informed Strategy Measures (ESMs).

Medsphere's EHR/RCM upgrade

The CHCC's Health Information Technology (HIT) department continues to collaborate with Medsphere for upgrades to the CareVue Electronic Health Record (EHR) and Revenue Cycle Management (RCM) system. CareVue EHR is a key data source for many National Outcome and Performance Measures, including the State Performance and Evidence-based Informed Strategy Measures used to inform the Title V Maternal and Child Health (MCH) Services Block Grant annual reports.

The current CareVue EHR has its limitations around interoperability and data exchange across different CHCC systems. CHCC is looking to enhance its EHR by implementing Electronic Case Reporting (eCR) that allows for automated exchange of data between electronic health records and public health agencies. This work is on-going and led by the CHCC Health Information Technology Department.

MCH Jurisdictional Survey

The CNMI SSDI project worked closely with HRSA and the National Opinion Research Center (NORC) at the University of Chicago, with its sub-contractor, Tebbutts Research, to enable a third round of the Maternal and Child Health Jurisdictional survey (MCH-JS) in the CNMI. The survey was conducted in late December 2023 with data analysis completed in March 2024. The first and second rounds of the MCH-JS were conducted in 2019 and 2021 respectively. The purpose of the MCH Jurisdictional Survey is to provide information on the health and well-being of mothers and children who resides in the eight United States-affiliated jurisdictions and to serve as a federally available data source to inform NOMs, NPMs, and other state indicators related to women and children's health.

The data collection methodology used for MCH-JS–19 was similar to the MCH-JS–21; the difference included the survey questionnaire, sample size, and survey geographical locations. For the MCH-JS-21, the survey questionnaire contained additional COVID -19 related questions similar to the added items on the recent National Survey of Children's Health questionnaires; increased sample size from 200, to 250 respondents, and larger geographical area that included the islands of Tinian and Rota with a sample size of 14 and 12 surveyed households respectively.

Data collection methodology used during MCH-JS-23 reflected the procedures used during MCH-JS-21. As with the MCH-JS-21, the MCH-JS-23, enumerators were instructed to maintain confidentiality, implement quality control procedures, randomize respondents (samples) and perform in-person interviews at the respondent's residence using paper and pencil interview (PAPI). Respondents were asked to answer questions using structured standardized questionnaires that were both quantitative and qualitative in nature. In all, 250 household interviews were completed at various geographic locations, but because of the small population size, certain indicators resulted with a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution.

Data obtained from the MCH-JS-23 survey are essential for meeting the federal reporting requirements and to demonstrate progress on National Performance and Outcome Measures (NPMs and NOMs), including the impact of Title V funding for improving the health and well-being of women and children in the CNMI.

Table 1 illustrates a comparison of key factors identified in MCH-JS-19, MCH-JS – 21 and MCH-JS-23.

Table 1. Comparison of key factors between the 2019, 2021, 2023 CNMI MCH Jurisdictional Surveys

Table 1			
Summary of Key Factors	**MCH-JS-19**	**MCH-JS-21**	**MCH-JS-23**
Enumerator Sites	Saipan	Saipan,Tinian, Rota	Saipan,Tinian, Rota
Targeted Sample Size	200	250	250
Total # of indicators (NOMs and NPMs)	33	33	Same
# of NOMs	14	14	14
# of NPMs	19	19	19
# and % of NOMs - Reliable estimates	7 or 50%	8 or 57%	7 or 50%
# and % of NPMs - Reliable estimates	5 or 26%	10 or 53%	10 or 53%
# and % of NOMs with "Indicators has a confidence interval width > 20% or 1.2 times the estimate and should be interpreted with caution"	7 or 50%	6 or 43%	7 or 50%
# and % of NPMs with "Indicators has a confidence interval width > 20% or 1.2 times the estimate and should be interpreted with caution"	14 or 74%	9 or 47%	9 or 47%

A new addition to the MCH-JS-23 included a chart book which illustrated graphs and tables of key survey findings for the CNMI.

CNMI SSDI Project Plan December 2022 – November 2027

IN FY2023, the CNMI was awarded by HRSA five-year funding to continue to support the SSDI project in the CNMI. The project annual award increased to $100,000, enabling the hiring of an additional staff member to provide support in the collection, analysis, and reporting of CNMI MCH data.

The goals, objectives, and activities described below make up the CNMI's SSDI Project work plan:

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming

Objective - By November 30, 2023, and annually through November 30, 2027, the Project will develop at least 2 data reporting products that will be updated on an annual basis.

Activity 1.1 - Develop Fact Sheets focused on Health Equity, Social Determinant of Health (SDoH) and relevant programmatic information

Activity 1.2 – Develop/update the CNMI Maternal & Child Health Surveillance and Monitoring Plan to inform decision making.

Activity 1.3 – Provide an annual update on the CNMI Maternal & Child Health Surveillance and Monitoring Plan

Activity 1.4 – Provide support for completing the CNMI Title V MCH Annual Block Grant/Application

Activity 1.5 – Coordinate the Comprehensive MCH 5-year needs assessment activities; SSDI Project Coordinator and MICAH Administrator will develop strategies to continuously monitor identified priorities and adjusted as needed based on information assessment and interim annual needs assessment updates.

The SSDI project is committed to addressing health disparities and advancing health equity by improving data equity. As a member of the CHCC Data Modernization Initiative Steering and Advisory committee, the SSDI project is involved in the discussions for the development Data Governance committee to oversee the planning and implementation of Data

Governance aimed at setting internal standards concerning data policies and regulation for data management including collecting, storing, processing, sharing, safeguarding and disposing.

The MCH trend analysis dataset is developed by SSDI to collect data and monitor the health experience of MCH population by tracking encounters involving the national performance and outcome measures, State Performance Measures, Evidence-based or- Informed Strategy Measures for informed-decision-making. Surveillance efforts consisted of identifying emerging or new cases affecting the MCH population through CNMI Syndromic Surveillance Report.

The SSDI project and MICAH Administrator are developing plans for implementing the next Comprehensive 5-year Needs Assessment using the Conceptual Framework by engaging Community partners and stakeholders early in the needs assessment process.

Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability
Objective - By November 30, 2027, there will be an increase of 6 percent, from FY 2020 baseline of 36 NOMs with data sources, to 38 NOMs with data sources used to inform the Title V MCH Block Grant Application/Annual Report.
Activities 2.1 - Collaborate with Program Managers and Stakeholders for developing and selecting data collection tools to address gaps for reporting on all MCH performance and outcome indicators
Activity 2.2 – Update/strengthen a data sharing agreement/MOU with CNMI Public School System (PSS)
Activity 2.3 - Develop data sharing agreement with Northern Marianas College.
Activity 2.4 - Coordinate with HIT and Medsphere for data extraction training.

The SSDI project is collaborating with MCH program managers for improvements in data collection and cleaning activities to ensure accurate data analysis and to provide high quality data for informed-decision-making.

By increasing the sample size for the MCH Jurisdictional survey, CNMI is posed to gain better survey results that reflects the MCH target population which can be used by management for informed decision making.

Goal 3: Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming
Objective - By November 30, 2027, the CNMI MCH Program will report on the use of at least 3 health equity metrics or SDoH metrics for identifying improvement opportunities and tracking the CNMI's progress as part of the Title V MCH Block Grant Application/Annual Report. Baseline data is not available.
Activity 3.1 – Convene a workgroup consisting of a diverse group of Health System representatives and community stakeholders to identify priority health equity metrics to track and inform progress on the MCH Title V Block Grant.
Activity 3.2 – Develop a data collection and monitoring plan to identify data sources, collection, and reporting timeframe for identified health equity metrics
Activity 3.3 - Develop data linkage of key MCH data sources with public health databases to track health equity metrics including race, ethnicity, income, gender, and geographic locations to reduce or eliminate health disparities and improve access to health.

The SSDI project is in the process of developing/upgrading the MCH trend analysis database to collect information on race/ethnicity, gender, insurance status, locality, age, educational attainment and other demographic information to for data linkage to improve health equity and informed-decision-making. The MCH trend dashboards is shared with MCH program

managers for use in information annual reports and plans for addressing the health and wellness needs of the CNMI MCH population.

Goal 4: Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19
Objective: Electronic Case Reporting (eCR) for more accurate Public Health reporting: By November 2023, and annually through November 30, 2027, the SSDI project will work to implement electronic case reporting (eCR) for improving the timeliness, accuracy and completeness of data to inform surveillance systems, prevent or contain outbreaks, and implement evidence-base intervention to protect population health.
Activity 4.1 - Coordinate with CHCC Health Information Technology (HIT) department, Electronic Case Reporting (eCR) team and Medsphere to discuss options for implementing eCR.
Activity 4.2 - Conduct audits of all MCH data sources, define standards for data formats to improve data linkages, and standardize existing data between all MCH data sources.
Activity 4.3 - Collaborate with Data Governance Council to assist in creating a data repository for all public health programs.
Activity 4.4 – Establish a Maternal & Child Health Data Dashboard to include Health Equity metrics.

The SSDI team is involved in the discussion of upgrading the current Electronic Health Record (EHR) to include the integration of electronic case reporting (eCR) which automates real-time exchange of case report data between EHR and Public Health agencies. The current EHR system lacks the capability to incorporate electronic case reporting.

Formalized by a charter, the CHCC Data Modernization Initiative (DMI) Steering and Advisory Committee is made up of representatives from various programs and departments across CHCC. The CHCC DMI Steering and Advisory committee was established to provide the strategic framework for proper oversight and decision making over the CNMI CHCC Health System's, inclusive of Public Health, critical data assets. The group will lead the planning and implementation of Data Governance framework for Commonwealth Healthcare Corporation.

SSDI Project Plan for the preparation and implementation of the next 5-Year Needs Assessment

In FY2023, the CNMI MICAH Programs, including the SSDI project team, began planning for the 2025 CNMI MCH Title V Comprehensive Needs Assessment. A timeline with action items was developed to help guide the effort and a steering committee was put in place to provide oversight and direction on the process. In FY 2024, a request for proposals was released to recruit a consultant to help facilitate key aspects of the needs assessment process. The 2025 CNMI MCH Title V Comprehensive Needs Assessment is scheduled to launch in the fall of 2024 and be completed by the spring of 2025 and subsequently reported in July of 2025.

The CNMI's plan for the next 5-year needs assessment is based on the Conceptual Framework provided by the MCH Evidence Center. The Framework involves[1]:

1. Engage Partners – engage community partners and have ongoing communication throughout the needs assessment process.
2. Assess Needs – Data sources for assessing needs of the MCH population include:
    a. Population-based data (census and vital records)
    b. Surveillance systems and survey data
    c. Program or service data
    d. Public forums or focus group data

3. Examine Strengths and Capacity – assessing current resources, activities and services by each of the three MCH service levels: Direct Services, Enabling service and Public Health Services and Systems.
4. Select Priorities – Involves examining needs and matching them with the desired outcome; methods used to select priorities include; Delphi process, Q-sort, public opinion, advisory and focus groups.
5. Setting performance objectives consists of two phases:
    a. Develop actions strategies to address priority needs using five National Performance Measures (NPMs), Evidence-based or -informed Strategy Measures (ESMs) for each of the selected NPMs, and State Performance Measures (SPMs).
    b. Set five-year targets (i.e., performance objectives) for the five selected NPMs, the ESMs and the SPMs.
6. Develop Action Plan - involves the planning and identification of specific activities to implement the program strategies; part of this process is to create the five-year State Action Plan Table, which at a minimum includes relevant priority needs, key strategies and measures for each of the MCH health domains.
7. Seek and Allocate Resources – Identify funding source for planned activities to address state priorities. Inputs include the five-year State Action Plan, current budgets, political priorities, and partnerships.
8. Monitor Progress - examine the results of efforts to gauge whether there has been improvement or change. Inputs include NOMs, NPMs, SPMs and ESMs, performance objectives and other quantitative and qualitative information.
9. Report Back to Partners - reporting to ensure accountability to partners who have worked with the MCH staff throughout the needs assessment process.

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[1]MCH Needs Assessment Toolkit, Frameworks and Tools, https://www.mchneeds.net/framework.php

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Other MCH data capacity efforts in the CNMI includes the following:

Pregnancy Risk Assessment Surveillance Monitoring System (PRAMS):

Commonwealth of the Northern Mariana Islands Pregnancy Risk Assessment Monitoring System (CNMI PRAMS) is a joint research project between the Commonwealth Healthcare Corporation (CHCC) and the Centers for Disease Control and Prevention (CDC). In 2021, the CNMI PRAMS project initiated a planning and preparation phase that involved the hiring of project staff, convening of a PRAMS Steering Committee, finalization of the PRAMS research protocol, and obtaining institutional research board (IRB) approval for the project. The CNMI PRAMS is a population-based surveillance system designed to identify maternal attitudes and experiences before, during and after pregnancy. Research indicates that maternal behaviors during pregnancy impact infant birthweight, gestation and mortality rates.

The goal of PRAMS is to improve the health of mothers and infants by reducing adverse outcomes, and promoting maternal health by influencing programs, policies, and maternal behaviors. CNMI PRAMS data will be used to establish an evidence base surveillance system for data-driven public health decision making and program development.

The objectives to meet the overall goal of PRAMS are to:

• Document estimates and trends in maternal and infant indicators
• Identify subpopulations at greatest risk for the adverse birth outcomes and inform prevention strategies
• Inform the HRSA Title V needs assessment process to aid the CNMI in planning for and allocating MCH block grant funds
• Develop programs and system changes that support improvement of maternal and infant health
• Investigate emerging issues in maternal and infant health, and monitor mortality and morbidity trends for the target populations
• Support health professionals to incorporate the latest research findings into their standards of practice
• Build state capacity by serving as a significant resource for data to promote and improve the healthcare system and inform programs and policies

Upon receiving approval from the CDC IRB, the CNMI PRAMS initiated the first batch for data collection in July 2022. Both traditional methods of mailing and phone are used to collect data from live birth samples. Data from the 2022 CNMI PRAMS was made available for analysis by the CDC to the CNMI in June of 2024.

The CNMI PRAMS team will be conducting an oral presentation at the 2024 National PRAMS grantee meeting and the 2024 CityMatch conference on the implementation of the PRAMS in the Pacific Islands.

Electronic Health Record (EHR) System: The CHCC transitioned into a new EHR system in November 2021. The Carevue EHR system implementation included the following public health reporting interphases:

1. 170.315 (f)(1): Transmission to Immunization Registries
2. 170.315 (f)(2): Transmission to Public Health Agencies – Syndromic Surveillance
3. 170.315 (f)(3): Transmission to Public Health Agencies –Reportable Laboratory Tests and Values/Results

After internal evaluations and assessment of system functionalities and challenges in the implementation and utilization of the Carevue EHR system, the CHCC made a decision in 2023 to identify and transition into another EHR system to better meet the needs of administrative, clinical and public health sections of the organization. For

Public Health, the transition to the Carevue EHR system greatly reduced the data capacity of the division as querying and accessing data by public health became practically impossible.

Immunization System linkage to EHR- System Interoperability: Through a partnership with the HIT Department, the Immunization Program is working on its initial phase of HL7 interfaces between the CNMI Immunization Information System (IIS) called the Weblz, and the CareVue HER. This upgrade will improve the capturing and reporting of vaccination data at CHCC.

National Electronic Disease Surveillance System (NEDSS) Base System (NBS)- The CNMI CHCC has implemented the NEDSS NBS for managing reportable disease data and the electronic transfer of the data to CDC. This project is led by the CHCC Epidemiology and Laboratory Capacity (ELC) Program.

Electronic Vital Registration System (EVRS)- Through the CNMI Health & Vital Statistics Office (HVSO), the CNMI has implemented the first electronic vital registration system, enabling the CNMI to participate in the Social Security Administration's Enumeration at Birth (EAB). The EAB allows parents to complete applications for Social Security numbers for their newborns as part of the CNMI birth registration process. The new EVRS will increase interoperability for system integration with other CHCC data systems, such as the newborn screening data system. Additionally, the new system will improve the CHCC capacity around morbidity and mortality surveillance as part of efforts for monitoring population health status within the CNMI.

Early Hearing Detection and Intervention (EHDI) System linkage: Updates to the newborn hearing screening data system was completed in 2020; the EHDI program completed its data linkage interphase with CHCC Heath and Vital Statistics EVRS database. The EDHI data system includes a module for capturing newborn bloodspot screening data and enables reporting on newborn screening rates and identification of infants who are diagnosed with a newborn metabolic condition.

Table 1, below, provides and overview of the CNMI MCH data sources utilized by the MCH Title V program to inform annual reporting and plans for interventions to address priorities for CNMI women and children.

Table 1. CNMI MCH Data Sources

Data Source	Periodicity	Electronic Form	Link to Vital Records	Information Gathered
HVSO Birth	Quarterly	Yes	Yes	Birth Rates, preterm births, prenatal, maternal morbidity and mortality, fetal and infant deaths, birth weights congenital anomalies, birth outcome
HVSO Death	Annually	Yes	Yes	
Medicaid	Monthly	Yes	No	Number of Pregnant women and children enrolled
Women Infant and Children (WIC)	Annually	Yes	No	Breast feeding rates, early childhood BMI data, Anemia screening
Healthy Outcome for Maternal and Early Childhood (H.O.M.E) Visiting Program	Semi-annual	Yes	No	Breastfeeding Rates
				Safe Sleep Practices/data
				Early Childhood Developmental Screening
Newborn Bloodspot Screening	Monthly	Yes	Yes	Number of infants who received newborn bloodspot
Newborn Hearing Screening	Monthly	Yes	Yes	Newborn hearing screening, diagnosis, and referrals rates
Family Planning Program	Monthly	Yes	No	Preventive Visits for Women ages 18-44
				Adolescent Visit Rates
PRAMS	Annually	Yes	Yes	Prenatal preventive visits, prenatal oral health, tobacco, betelnut and e-cigarette use
CHCC Dental/Oral Health Program	Annually	Yes	No	Dental caries rate
				Children preventive dental visit rates
				Prenatal preventive visits rates
				Oral cancer screening rates
Developmental Screening	Monthly	Yes	No	Number of children ages 6 - 60 months who received ASQ
Breast & Cervical Cancer Screening Program	Annually	Yes	No	Breast and Cervical Cancer Screening Rates
CNMI Cancer Registry	Annually	Yes	No	Cancer Diagnosis Rates
Immunization WebIz	Daily	Yes	No	Childhood Immunization Rates
Early Intervention	Annually	Yes	No	Number of CSHCN 0-3 enrolled
Special Education	Annually	Yes	No	Number of CSHCN 3-21 enrolled
Public School Systems	Annually	Yes	No	Youth Risk Behavior Survey, School and SPED enrollment
Maternal and Child Health Jurisdictional Survey	Every 2 years	Yes	No	NOM - 1, 4, 5, 14, 17.1, 17.2, 17.3, 17.4, 18, 19, 20, 21, 24, 25
				NPM - 1, 4a, 5a, 6, 7.1, 7.2, 8.1, 8.2, 9, 10, 11a, 11b, 12a, 12b,
CNMI NCD Hybrid Survey	Every 5 years	Yes	No	Rates for preventive Visits for Women, tobacco and alcohol use, physical activity, nutrition, hypertension, diabetes

III.E.2.b.iv. MCH Emergency Planning and Preparedness

Northern Mariana Islands Emergency Management Structure

Homeland Security and Emergency Management: The CNMI Homeland Security and Emergency Management (HSEM), located within the Office of the Governor, is the emergency management agency for the territory. The CNMI Governor has direct authority over the CNMI HSEM which serves as the coordinating agency for all emergency management services, federal emergency management agencies, the private sector, and nongovernmental organizations.

The HSEM develops and maintains the CNMI All-Hazards Emergency Operations Plan, which establishes the shared framework for the CNMI's response to and initial recovery from emergencies and disasters. CNMI agencies responsible for providing emergency assistance are organized into 18 functional groups, emergency support functions (ESF). Each ESF outlines responsibilities of state agencies and partners for emergency functions and provide additional detail on the response to specific types of issues and incidents.

The purpose of the CNMI All-Hazard Emergency Operations Plan (EOP) is to establish the CNMI Emergency Operations System which organizes the CNMI's response to emergencies and disasters while providing for the safety and welfare of its people. It sets forth lines of authority, responsibilities and organizational relationships, and shows how all actions will be coordinated among the CNMI, its various Municipalities and the Federal Government. The EOP is designed as an "ALL HAZARDS" plan and applies to all hazards identified in the Hazard Identification Risk Assessment found in the CNMI State Standard Mitigation Plan (SSMP)[i]. The CNMI EOP defines operational structures to perform the following functions:

- Coordinate emergency management plans at the federal, state, and local government levels. Outlines the activation and coordination processes of the CNMI's Emergency Operations Center (EOC) and associated functions.
- Effectively utilize government (federal, state, and local), non-governmental organizations, and private sector resources through the response mission arena of emergency management.
- Provide a system for the effective management of emergencies, including describing how people (unaccompanied minors, individuals with disabilities and others with access and functional needs, and individuals with limited English-speaking proficiency) and property are protected.

Public Health/Hospital Emergency Preparedness Program: The CHCC public health and hospital Emergency Disaster Plan (EDP) outlines how the health department and hospital will manage the impacts of an emergency and execute duties assigned by the CNMI EOP. The lead division for emergency management under the CHCC is the Public Health/Hospital Emergency Preparedness Program (PHHEPP) which is located under the office of the Chief Executive Officer. PHHEPP works to prevent, mitigate, plan for, respond to, and recover from natural and human-caused health emergencies and threats. The PHHEPP is also responsible for the coordination of the CNMI Medical Reserve Corps (MRC) that provides volunteers to assist with emergency operations.

CHCC/Health Department Functions in the CNMI EOP: Within the CNMI EOP, the CHCC is the lead agency for the ESF8 functions, Health and Medical Services. In this role, the CHCC is responsible for coordinating, communicating and serving as the liaison with federal and response agencies concerning public health and medical emergencies. It leads the coordination and facilitation of public health support of individuals and communities under evacuation, quarantine, or isolation for incidents involving the release of chemical, biological, radiological, nuclear, and explosive materials; natural and man-made disasters; and major disease outbreaks. The CHCC is responsible for public information and risk communication prior to, during, and following a public health or medical emergency to the CNMI EOC. Additionally, the CHCC is responsible for public health screening, testing, vaccination, treatment and other public health services during a public health medical emergency requiring the services. The CHCC serves in support capacity for the following ESFs: 2 (Communications), 5 (Information and Planning), 6 (Mass Care), 10 (Oil and Hazardous Materials Response), 11 (Agriculture and Natural Resources), 14 (Long-term Community Recovery), 16 (Volunteers and Donations), 17 (Cyber and

Critical Infrastructure Security).

Maternal & Child Health (MCH): Both the CNMI EOP and the CHCC EDP have limited language that specifically addresses the needs of maternal and child health. There is also minimal language for those with access and functional needs, which can include pregnant women and children.

When an imminent or actual emergency occurs, the CNMI HSEM coordinates the CNMI's response through the activation of the CNMI Emergency Operations Center (EOC). During an emergency, the CHCC establishes an emergency response structure to coordinate the CHCC's activities using the Incident Command Structure Agency Operations Center (AOC). The PHHEPP is responsible for training staff to fulfill the leadership roles in the AOC for planning, operations, and logistics sections chiefs, as well as section staff. Staff of the Division of Public Health Services have been trained and served on emergency management leadership and support roles before and during the pandemic as part of the CHCC AOC.

The CNMI's Title V Director has served as the AOC Operations Chief for Vaccinations with various Title V staff members supporting operations sections/functions, communications, and planning.

AMCHP Emergency Preparedness and Response Learning Collaborative (ALC): In 2021, the CNMI participated in the AMCHP Emergency Preparedness and Response Learning Collaborative opportunity to address emergency preparedness for the MCH population. CNMI participants included representatives from MCH Title V along with staff members from the CHCC PHHEPP.
Participation in the ALC resulted in the identification of strategies for strengthening MCH focused activities within the CHCC EDP and the EOP, including the following:

Strategy: Integrate MCH considerations into state/territory EPR Plan
Strategy: Develop a plan to gather epidemiologic/surveillance data on women of reproductive age and infants to guide action

These activities are on-going work to implement the strategies continues into FY2023 -2024.

Title V Preparedness Efforts: The CNMI's Title V Director works collaboratively with the CHCC PHHEPP Director in supporting emergency preparedness and response training and in developing communications plans and other strategies for improve CNMI wide emergency preparedness and for responding to threats, including those that impact the MCH populations. in During the recent COVID-19 pandemic, the Title V Director was involved in CNMI-wide vaccination planning discussions including the identification and implementation of vaccination for priority populations, including: healthcare workers, first responder, teachers and childcare workers, the man'amko (elderly), and worked to expand population access in a phased approach as vaccine availability moved from limited to broad supply.

The Title V Director was significantly involved in the development of standard operating procedures which operationalized COVID-19 mass vaccination operations and that served as the framework for vaccine points of dispensing (PODs) during the initial and subsequent phases of the COVID-19 vaccination roll out. Additionally, working collaboratively with the CHCC AOC Communications team, the Title V Director led a team to support the development of standard operating procedures, a vaccination registration data system framework, reporting metrics, and facilitated training to establish a CNMI COVID-19 vaccination call center as part of strategies to ensure information and access to vaccinations were communicated as widely and quickly as possible to the CNMI Population.

Throughout the pandemic, Title V Programs provided leadership for their programs to develop policies and procedures in alignment with CDC and CHCC guidance, federal and local mandates, and the Governor's executive orders. Adaptations to programs had to be implemented for the health and safety of staff, families, and the community.

The following information describes recent efforts that demonstrates the extent that CNMI MCH Title V program participates

in developing and coordinating plans that enhance CNMI wide preparedness for addressing impacts of disasters and threats to the MCH populations:

Newborn Metabolic Screening- staff worked closely with the CNMI hospital nursery department, pediatricians and the CHCC laboratory to ensure that specimen collection prior to discharge for babies born. Staff monitored screening results to ensure that follow-up services were initiated timely to minimize risk for loss to follow-up. Additionally, what use to be a limited weekly window for collecting specimens at the nursery ward was modified to enable a 7-day specimen collection to further reduce the risk for loss to follow-up of babies born outside the specimen collection window.

Newborn Hearing Screening staff continued to work to ensure babies had a hearing screening before discharge after birth. The EHDI Program Coordinator worked closely with the hospital nursing staff to ensure that babies who were referred for follow-up or diagnostic audiological screening services were seen and not lost to follow-up. There were some challenges during the initial phases of the pandemic in conducting annual calibration for hearing screening equipment as the off-island vendors from Oregon were not able to enter the CNMI to perform services due to travel quarantine protocols. To address this, program had to negotiate loaner equipment and work to send equipment to the state of Oregon to complete annual equipment calibration requirements. However, in 2022, travel restrictions and quarantine protocols were lifted and on-site calibration of the hearing screening equipment resumed.

Home Visiting services were modified to tele-home visits, following guidance from HRSA and in compliance with the CNMI Governor's executive orders. Home visitors continued to provide services and continue participant recruitment throughout the pandemic by utilizing video conferencing or phone access. Support was offered to families who did not have means to connect virtually by providing them prepaid cellular cards and mobile phone units to access weekly home visits. Emergency supplies were also made available to program participants, including infant diapers, wipes, disinfecting supplies, and grocery store vouchers for food. In July of 2022, the program leadership adopted a tiered approach based on household risk factor for severe disease for transitioning services back to face to face home visits, in alignment with the easing of COVID-19 restrictions in the CNMI.

WIC waivers were extended by the USDA, allowing the CNMI WIC Program and its clinic to provide all services remotely by phone, mail, and electronic correspondence. The CNMI WIC had fully implemented eWIC in 2018 which enable families to continue accessing food benefits via electronic transfer benefits (EBT) throughout the pandemic. The CNMI WIC worked with WIC enrolled vendors to implement the WIC-to-go services allowing WIC participants to purchase WIC approved products over the phone and to schedule pick up. The project aimed to cut shopping time and also minimize time spent in public places as part of social distancing measures.

Immunization services and activities focused on routine vaccinations continued throughout the pandemic. The CNMI Immunization program strengthened its outreach activities and worked closely with public and private schools to monitor vaccination rates and coordinate mobile vaccination activities to ensure that kids are kept up to date with routine vaccine recommendations.

Early Intervention Program is the CNMI's IDEA Part C program. Services were modified to phone visits and/or videoconferencing via the Zoom platform and then transitioned back to face to face at the start of the 2022 school year.

Children with Special Healthcare Needs Program offered parent/peer support services through telephone and videoconferencing and gradually transitioned back to face to face services by the summer of 2021. Learning sessions and trainings for parents of CSHCN and service providers were conducted virtually through Zoom. Despite COVID-19, Shriner's outreach clinics were successfully completed on Saipan twice in 2021.

Group Prenatal Care Group prenatal visits were suspended due to COVID-19 pandemic restrictions and social distancing requirements that made it difficult to coordinate face to face visits for groups of 8 to 10 women and their partners. Access to equipment and internet connection were challenges identified and made it difficult for group prenatal care to successfully transition to virtual sessions. Additionally, a virtual platform made it impossible for screenings and measurements to be

conducted. The MCH program coordinated the transition all group prenatal clients to the CHCC Women's Clinic for prenatal care to be accessed.

COVID-19 Lessons: The COVID-19 pandemic identified gaps in planning and operations as well as resulted in the development of innovative strategies to address them. Timely and accurate information was a priority area identified to be able to effectively communicate information regarding COVID and to dispel misinformation about vaccinations through linguistically and culturally appropriate information. Title V staff worked closely with medical providers to produce social media messaging and public awareness videos to promote information from trusted messengers on the benefits of vaccination. Social media posts and videos promoting vaccinations among pregnant and breastfeeding women, children and teens were developed and aired on the local cable news network as well as the local movie theater. A call center was established through telephone number (670) 682-SHOT [7468] as a centralized communication hub for community members to be able to speak to a live representative.

PRAMS & COVID-19: In 2021, the CNMI began the implementation of its PRAMS project and in 2022 was able to secure IRB approval of the survey protocol through a reliance agreement with the Hawaii Department of Health IRB. The CNMI PRAMS samples 100% of all resident births in the territory and will began with 2022 births. Included in the CNMIs PRAMS questionnaire are questions about experiences with prenatal care, delivery, postpartum care, infant care during the pandemic, and COVID-19 vaccinations. The data collected during the initial year of the CNMI PRAMS was made available to the CNMI in June of 2024. The information gathered in the COVID-19 module of the questionnaire will be utilized to inform the CNMI preparedness planning and activities specific to the MCH population.

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[i] Commonwealth of the Northern Mariana Islands. (2018). Standard State Mitigation Plan. Retrieved on July 16, 2023 from https://opd.gov.mp/library/reports/2018-cnmi-ssmp-update.pdf

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

III.E.2.b.v.a. Public and Private Partnerships

The CNMI MCH Title V program utilizes a collaborative approach to leverage federal funding and maximize local funding to assure the delivery of healthcare services for the CNMI MCH population.

The MCH Title V Program is administered under the CHCC Maternal, Infant, Child and Adolescent Health (MICAH) unit. Preventive and primary care services for women and children are provided at the CHCC Women's Clinic, Children's Clinic – both located at the hospital on Saipan; and Rota and Tinian Health Centers- located on the islands of Tinian and Rota respectively. Services for the MCH population include prenatal care, postpartum care, women's health, education and counseling, case management of high-risk pregnancies, family planning, HIV/STI Prevention, and preventive screenings such as mammogram, pap smear, blood pressure screening, diabetes screening with multiple methods of blood sugar testing, well-child visits, developmental screenings for infants and children, newborn screening, and oral health services. Since its inception, MICAH programs, formerly the CHCC Maternal and Child Health Bureau (MCHB), and primarily the MCH Program, has worked diligently with the CHCC outpatient clinics and its medical providers on applying evidence-based approaches towards improving healthcare and health outcomes within the population.

In addition to working closely with CHCC clinic providers and other Public Health programs, the MCH program works with community-based partners on various projects. A significant role that MCH plays towards ensuring access to healthcare is by working towards reducing barriers to access to care. The inability to pay or lack of insurance is often cited as a major obstacle in seeking preventive healthcare. The MCH Program works with the CNMI Medicaid agency to offer expedited application processing for women and children in the CNMI and receives referrals of at-risk women or children from partner agencies and medical providers.

The CNMI Title V program regularly collaborates with federal, state, and non-governmental agencies towards efforts to improve and ensure access to quality health care and needed services for the CNMI MCH population:

- Centers for Disease Control & Prevention (CDC)
    - Pregnancy Risk Assessment Monitoring System (PRAMS)
        - Development of the CNMI PRAMS Protocol for implementation
    - Program Operations and Assessment Branch
        - The CNMI receives on-going technical assistance on immunizations and vaccine storage and handling, vaccine coverage assessments, and Immunization Information System (IIS) maintenance.

- CHCC-Health Disparities Program
    - The Health Disparities Program (HDP) works to reduce disparities and support the well-being of our community by providing accessible and affordable healthcare in rural areas. The CNMI Title V program collaborates with the HDP to deliver enabling services to meet the ongoing needs of a patient and address factors that may affect health, such as transportation, food and housing, education and other social assistance.

- Association for Maternal & Child Health Programs (AMCHP)

- Innovation HUB replication Project
  - The CNMI applied and received approval for funding and support through AMCHP to replicate the implementation of the Providers and Teens Communication for Health (PATCH) Program in the CNMI. The AMCHP awarded the CNMI MCH Program with $25,000 to implement the PATCH program.

- Commonwealth Office on Transit Authority (COTA)
  - CNMI Public Transportation System
    - CHCC MICAH Programs works with COTA to provide public transportation services at a discounted rate or at no cost to pregnant women, mothers, children and CSHCN to meet their appointment needs for the Children's Clinic, Women's Clinic, Immunization and Early Intervention Program.

    - COTA is reservation based, curb-to-curb, and door to door service that is offered to anyone on island. All CARS/Paratransit vehicles are ADA compliant.

- Hawaii Department of Health
  - There currently is a reliance agreement between the Division of Public Health and the Hawaii Department of Health to enable the CNMI PRAMS project to utilize the Hawaii health department IRB for the CNMI PRAMS project.

- Department Community and Cultural Affairs (DCCA)
  - Division of Youth Services (DYS)
    - The Memorandum of Understanding (MOU) between the Commonwealth Healthcare Corporation (CHCC) Maternal, Infant, Child and Adolescent Health (MICAH) Programs and the CNMI Department of Community and Cultural Affairs (DCCA) Division of Youth Services (DYS) seeks to improve adolescent health and well-being in partnership with young people. The partnership described aims to establish and implement the Providers and Teens Collaborating for Health (PATCH) program in the Commonwealth of the Northern Mariana Islands (CNMI). PATCH provides engaging workshops for Providers and Peers advocating to improve adolescent health.

- CNMI Public School System
  - CHCC MICAH programs partner with the CNMI Public School System (PSS) to address various child and adolescent health initiatives. The partnership activities include school-based services to offer adolescent sexual and reproductive health services and education, vaccinations, early intervention services, and training or capacity building activities on child health related topics.

- Kagman Isla Community Health (KICH) & Tinian Isla Community Health Centers (TICH)
  - The KICH and TICH are Federally Qualified Health Centers (FQHC) on the islands of Saipan and Tinian, respectively. The CHCC Division of Public Health MICAH Programs partners with the CNMI FQHCs in efforts to expand vaccination coverage to ensure access to vaccines for the CNMI pediatric

population. This partnership is formalized through an MOU and includes:

- Access to CDC funded vaccines for uninsured or underinsured children and adults, including pregnant women.
- Training on vaccine storage and handling
- Patient education/informational materials

CNMI MCH Title V program staff also participates in critical partnerships and systems-building efforts and through these groups work to meet the needs of MCH populations in the CNMI:

- Early Intervention Interagency Coordinating Council (ICC): ICC serves as broad representation of stakeholders who provide input to the EI program in making infrastructure decisions that will impact services for infants and toddlers with disabilities and their families. The ICC remains the center meeting point for all the collaborating partners.

- Disability Network Partners (DNP): The Disability Network Partners (DNP) is a collaborated effort between CNMI Government Agencies to enhance the lives of individuals with Disabilities or Developmental Disabilities. The DNP collaborates to support opportunities for Individuals with Developmental Disabilities or Individuals with Disabilities (IWDD/IWD) inclusion and accessibility to participate and engage in all events that improve their quality of life.

- Developmental Disabilities Council: The DD Council's mission is to promote systems change to ensure that individuals with developmental disabilities and their families have the same opportunities as others in the community.

- CNMI PRAMS Steering Committee: Provide input for the development or selection of state-specific questions for the survey tool; use dissemination, and application of survey findings; recommendations on developing or modifying intervention programs.

- CNMI PMHCA Project: This is a newly established advisory council under CHCC-Community Guidance Center. The Pediatric Mental Healthcare Access (PMHCA) Program will enable improvements and expansion of mental health care for our CNMI children and strengthen current services across the primary health clinics, hospitals and school systems that will allow for a comprehensive and coordinated care. The CNMI MCH Title V Director currently sits as the Chairperson for PMHCA Advisory Council.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

CNMI became a territory in 1978 and its Medicaid program was established in 1979. It is a 100% fee-for-service delivery system with one hospital servicing the territory. There are no deductibles or co-payments under the CNMI Medicaid program, and the territory does not administer a Medicare Part D Plan. Instead, the Medicaid program receives an additional grant through the Enhanced Allotment Plan (EAP) which must be utilized solely for the distribution of Part D medications to dual-eligible.

Medicaid operates differently in CNMI than in the states. The territory is the only U.S. jurisdiction to participate in the Supplemental Security Income (SSI) program and Medicaid eligibility is based on SSI requirements. All individuals receiving SSI cash payments are eligible for Medicaid by simply filing out an application.

The framework for Medicaid financing in the CNMI resembles that of the fifty states: the cost of the program (up to a point) is shared between the federal government and the Territory, and the federal government pays a fixed percentage of the CNMI Medicaid costs. However, unlike the states, rather than having an open-ended financing structure, Medicaid for the CNMI is constrained by an annual ceiling on federal financial participation, referred to as the Section 1108 cap or Section 1108 allotment. This means that the CNMI, as do other US territories, receive a set amount of federal funding each year regardless of changes in the number of enrollees and the use of services. In contrast, states received federal matching funds for each state dollar spent with no cap.
The second difference is that the federal assistance percentage (FMAP) is statutorily set at 55 percent rather than being based on per capita income.

It was estimated by the Medicaid and CHIP Payment and Access Commission (MACPAC) that if the methodology for calculating the FMAP for the states would be applied to the CNMI, the CNMI would qualify for the statutory maximum in Title XIX set at 83%. This economic disparity is clear in the 2010 Census data: the median household income for a family of four in the CNMI was $19,958, while the U.S. national median household income was nearly 2.5 times that amount $63,179. Pre-PPACA, the CNMI and other territories were statutorily capped at 50 percent. In 2011, the rate increased to 55 percent FMAP and jumped again to 57.20 percent until December of 2015, and has dropped again to 55 percent FMAP. In contrast, some states receive over 80 percent FMAP.

The limit on federal Medicaid funding implement for the territories places huge risks in coverage for patients and creates financial strain in the CNMI's healthcare system and providers that serve Medicaid patients. These limitations have resulted in chronic underfunding of the program in the CNMI and has required US congress to intervene at multiple times to provide additional resources to prevent the health systems in the US territories from collapsing.

Recent supplemental federal funds have been made to the CNMI, beginning with the FY2020 appropriations package (PL 116-94, the Further Consolidated Appropriations Act of 2020), signed into law in December 2019 and then the Families First Coronavirus Response Act (FFCRA), effective March 2020.

These supplemental funds raised the CNMI's FY2020 Medicaid funding allotments from $6.9 million to $63.1 million and its FY 2021 allotment from approximately $7.1 million to $62.3 million. For FY 2022 and FY 2023, the federal funding allotments for the CNMI Medicaid program was $64 million and $66 million, respectively. In addition to supplemental federal funding, the FMAP rates for the US territories were also increased. The FMAP rate for the

CNMI was temporarily increased from 55% to 83% from FY2020 through FY2022. In December of 2023, the Consolidated Appropriations Act of 2023 made the 83% FMAP rate for the CNMI permanent, along with most of the other territories.

Table I below illustrates annual federal capped funding for the territories is significantly increased for the span of five years funding for the territories.

Table I. Annual Federal Capped Funding
FY2019-2023
($ in millions)

	FY19	FY20	FY21	FY22	FY23
CNMI	7	63	62	64	66

Source: https://crsreports.congress.gov

Congress has, over time, provided increases in federal funds to the CNMI for response to disasters and other specific emergency events. These temporary actions can provide short-term relief but also creates what has been called “funding cliffs” that require ongoing congressional action. To note that in FY 2019, an additional $36 million in federal funding was provided to the CNMI as a result of the disaster caused by Super Typhoon Yutu.

On September 24, 2021, six days before the end of FY2021, the CNMI Medicaid program was provided notice that CMS would be applying flush language following section 1108(g)(2)(E) in calculating the territorial federal allotments for FY 2022 and beyond. This resulted in FY2021 used as the base year for the calculation used to determine the allotment in FY2022. The funding amount for FY 2023 was determined based on the FY 2022 funding provided to the CNMI.

In recent years, the CNMI Medicaid program submitted the following State Plan Amendments:

- May 20, 2020: State Plan Amendment in response to the COVID-19 national emergency. The amendment allowed less strict income methods for determining eligibility, allow the SMA, hospital and public health centers to make presumptive eligibility (PE) decisions, and allow 12 months’ continuous eligibility for children under age 19.
- May 20, 2020: Amendment to cover the new optional group for COVID testing, continue to consider residents who leave the Territory due to the disaster residents of the Territory, extend the reasonable opportunity period, allow 90-day supplies of drugs and early refills, extend all prior authorizations for medications without clinical review, or time/quantity extensions, allow exceptions to the Territory's preferred drug list in case of shortages, and allow use of telehealth methods in lieu of face-to-face reimbursed at 80% of the face-to-face rate.
- June 09, 2020: The amendment allows hospital services provided by Commonwealth Healthcare Corporation (CHCC) using telehealth to be cost-reimbursed using the existing state plan cost protocol.
- May 28, 2021: Effective January 1, 2021, the amendment adopts the option to provide Medicaid eligibility without a 5-year waiting period to otherwise eligible individuals who lawfully reside in the Commonwealth of the Northern Mariana Islands in accordance with the Compacts of Free Association (COFA) between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Additional funding coupled with state plan amendments, such as Presumptive Eligibility has resulted in significant increases in Medicaid enrollment. According to the most recent available data provided by the CNMI Medicaid office on Medicaid coverage, in 2022 there were approximately 47,000 individuals in the CNMI receiving Medicaid benefits, of which it was estimated that 24,000 were accessing services via Presumptive Eligibility determination[i].

The Public Health Emergency ended on May 11, 2023 and subsequently benefits available to those enrolled via presumptive Medicaid enrollment ceased on May 31, 2023. Additionally, according to data received from the CNMI Medicaid Program for 2023, there are approximately 7,574 children ages 1 through 17 years enrolled in the CNMI Medicaid program.

The partnership between the MCH program and the CNMI Medicaid program, as indicated in an interagency agreement, includes referrals, Medicaid reimbursement for services eligible under the Medicaid State Plan, data sharing, and training. The Medicaid program provides eligibility and enrollment information to the MCH program on an annual basis. Additionally, the Medicaid program allows for the processing and expediting of MCH client applications and provides training to MCH program staff on Medicaid eligibility and application processing. The CNMI Medicaid program is operated under a 100% fee for service model. When needed health services are not available within the CNMI, the Medicaid program, through CHCC Health Network review board, provides coverage for off-island medical care to those enrolled.

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[i] Commonwealth Medicaid Agency. (2022). 2022 Citizen-Centric Report. Retrieved on July 13, 2024 from https://cnmileg.net/resources/files/2022%20CENTRIC%20REPORT/Medicaid%20CCR22.pdf

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

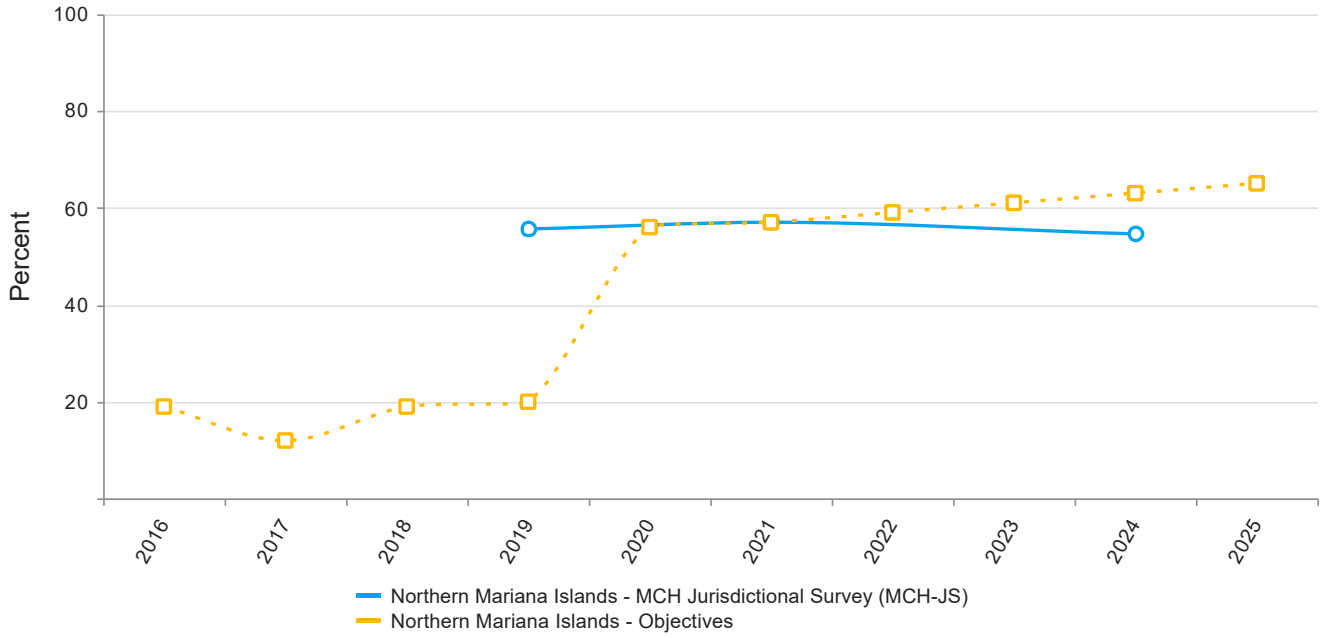
State Action Plan Introduction

As part of the MCH Title V Program, the CNMI developed a five-year State Action Plan to address the priority needs for the CNMI's MCH population. The plan presented in this year's submission outlines both the planned activities for the upcoming FY2025 as well as a report on activities that were completed in the reporting year, FY2023. The CNMI's plan is organized by six reporting domains, which include the following: Women/Maternal Health, Perinatal/Infant Health, Child Health, Children with Special Healthcare needs, and Adolescent health. The sixth domain addresses state-specific Cross-cutting/Systems Building needs.

Women/Maternal Health

National Performance Measures

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		56	57	59	61
Annual Indicator	55.5	55.5	57.1	57.1	54.5
Numerator	6,544	6,544	7,415	7,415	5,531
Denominator	11,784	11,784	12,993	12,993	10,143
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021	2024

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	20	56	57	59	61
Annual Indicator	22.7	25.4	65.4	53.1	
Numerator	1,757	1,959	5,047	4,057	
Denominator	7,742	7,721	7,717	7,641	
Data Source	CNMI EHR Pap Exam, International database estimate	CHCC Preventive Visits and US international census	CHCC EHR/RPMS Preventive visits	CHCC CareVue EHR Preventive Visits	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	63.0	65.0

Evidence-Based or –Informed Strategy Measures

ESM WWV.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.

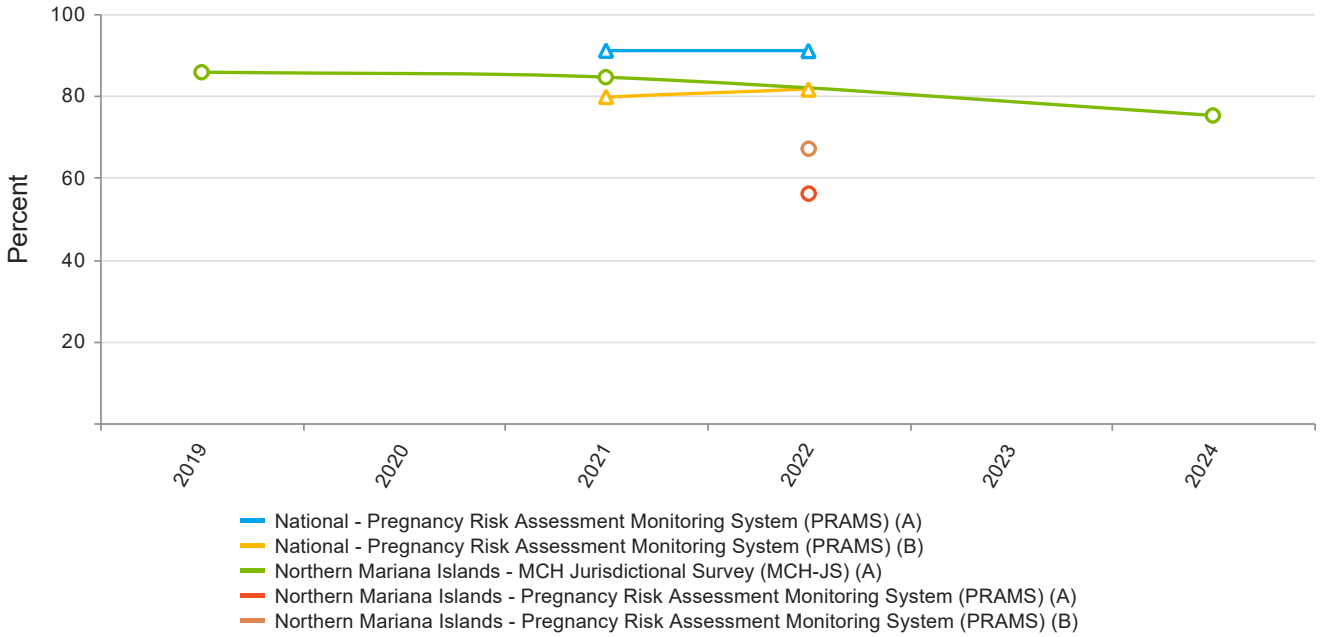
Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			5	49	53
Annual Indicator			65.4	53.1	28.6
Numerator			5,047	4,057	2,170
Denominator			7,717	7,641	7,595
Data Source			CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	35.0	40.0

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	56.0
Numerator	250
Denominator	447
Data Source	PRAMS
Data Source Year	2022

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS)	
	2023
Annual Objective	
Annual Indicator	75.1
Numerator	411
Denominator	548
Data Source	MCH-JS
Data Source Year	2024

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	67.0
Numerator	167
Denominator	249
Data Source	PRAMS
Data Source Year	2022

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Women/Maternal Health - Entry 1	
Priority Need	
Ability to find and see a doctor when needed (access to health services)	
NPM	
NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	
Five-Year Objectives	
By 2025, increase the number of women who access preventive visits to 65%, an increase from the baseline of 55%	
Strategies	
Expand access: Outreach and/ or Increased clinic hours. Conduct community awareness activities to promote women's preventive health visits.	
ESMs	Status
ESM WWV.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.	Active

NOMs

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

State Action Plan Table (Northern Mariana Islands) - Women/Maternal Health - Entry 2

Priority Need

Ability to find and see a doctor when needed (access to health services)

NPM

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Five-Year Objectives

By 2025, the CNMI will determine the baseline number of women who attended a postpartum checkup within 12 weeks after giving birth and the percent of women who attended a postpartum checkup and received the recommended care components.

Strategies

Utilize the CNMI PRAMS data to identify the baseline number of women completing postpartum checkups and the percentage receiving recommended care components.

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

In 2023, the US Census International Database estimates the CNMI population of women ages 18 through 44 years old to be 8,252. At the begging FY2023, the MICAH programs through the MCH Services Manager, continued to provide support to pregnant women and children for expedited processing of Presumptive Eligibility for Medicaid application under the CHCC financial assistance program. However, the Public Health Emergency subsequently ended on May 11, 2023, resulting in the Presumptive Eligibility under the CNMI Medicaid Program to end. Through continued collaboration and partnership with the CNMI Women's Clinic department, the MCH program continues to maintain an office space at the Women's Clinic as part of efforts to streamline patient referrals and enable tandem visits to minimize loss to follow up. This physical presence of Public Health Services in the clinical space allows the MICAH programs to efficiently address barriers to care and other risk factors patients may be identified with as well as reduce loss to follow-up.

The priority identified through the 2020 comprehensive MCH needs assessment process for women's health in the CNMI was "Access to health services- ability to find and see a doctor when needed." This priority is aligned with the national performance measure (NPM) 1, percent of women ages 18 through 44 years with an annual preventive visit. The data source that informs the NPM 1 is the MCH jurisdictional survey, which was conducted initially in 2019, updated in 2021 and 2023. According to the MCH-JS survey conducted in 2023, 54.5 percent of women ages 18-44 years in the CNMI reported accessing an annual preventive visit, a 2.6 percentage point decrease from the prior reporting year (see table NPM 1, below).

Priority: Access to health services- ability to find and see a doctor when needed.

NPM 1: Percent of women ages 18 through 44 years with an annual preventive visit.

Year	2019	2020	2021	2022	2023
Percent	55.5	55.5	57.1	57.1	54.5
Numerator	6,544	6,544	7,415	7,415	5,531
Denominator	11,784	11,784	12,993	12,993	10,143

Source: MCH Jurisdictional Survey

Based on the MCH Jurisdictional Survey conducted in 2019, in 2020, 55.5 percent of women ages 18 through 44 years reported an annual visit. In 2021, a second round of survey was conducted and indicated slight increase in this measure to 57.1 percent. The survey has been conducted every two years since its inception and thus prior year data is used during interim years to inform this measure. Based on data from the MCH-JS conducted in 2023, 54.5 percent of women ages 18 through 44 years reported an annual preventive visit, a 2.6 percentage point decrease from the prior report, bringing the measure to pre-pandemic levels.

Strategy: Expand preventive healthcare access- increase clinic hours and service sites.

In FY2023, the CHCC outpatient clinics launched the Mobile Clinic, which was acquired through funding made available by the US Housing and Urban Development (HUD) through the CNMI Northern Mariana Housing Corporation. The CHCC Mobile Clinic serves as an extension of the CHCC Outpatient Clinic, bringing primary and preventive healthcare access for adults, women, and children into various village settings on the islands of Saipan. In FY2023, the CHCC Mobile Clinic served a total of 203 CNMI women ages 18 through 44 years during outreach clinics. The MICAH programs work with the Mobile Clinic team members to compensate for provider time, promote the clinic schedule, and support referrals needed by women who access clinic outreach.

Additionally, through a collaboration with the Rota Health Center, Women's Clinic, and Breast & Cervical Cancer Screening program, MCH Title V was able to support monthly Women's Health Clinic outreach to the island of Rota to provide services such as Well-Woman Visits, breast and cervical cancer screening, prenatal care, and family planning. In FY2023, there were a total of 102 women from Rota who accessed women's health services during the monthly outreach clinic.

Evidence Based Strategy Measure 1.1: Percentage of women who report accessing preventive health services at CHCC.

Year	2021	2022	2023
% Served	65.4	53.1	33.0
Numerator	5047	4057	2507
Denominator	7717	7641	7595

In 2021, the MICAH programs began data collection utilizing the CHCC health system's centralized electronic health record (EHR) system to inform ESM 1.1: Percent of women who report accessing preventive health services at the CHCC including areas like the Family Planning and Mobile Clinic areas. Utilizing ICD-10 codes, provider narrative, and chief complaint or purpose of visit (POV) fields available in the EHR, the program was able to identify the number of women accessing preventive health services through all CHCC sites, including locations on the islands of Tinian and Rota. The denominator value is based on the population estimate available through the US Census International database of women in the Northern Mariana Islands ages 18 through 44 years and the numerator is based on the number of women of the same age range accessing preventive health services at the CHCC health system. In 2023, 33 percent of the women population ages 18-44 years in the CNMI accessed preventive health services at the CHCC, a 20.1 percentage point decrease compared to the prior reporting year.

In May 2023, as a result of the end of the Public Health Emergency, the CNMI Medicaid Program ended Presumptive Eligibility processing in the CNMI. Resulting in the loss of Medicaid access to thousands of residents in the CNMI. According the CNMI Medicaid Agency's FY2022 Citizen-Centric Report, there were approximately 24,000 individuals that accessed Medicaid coverage through Presumptive Eligibility.

The MICAH program's objective for this is ESM is for an increase to 57 percent in the year 2025, however, with the loss of the Medicaid access through Presumptive Eligibility, this target may be challenging to attain considering the financial barriers to care experienced by large segment of the CNMI population and may need to be adjusted.

Another strategy for providing access to preventive health services to CNMI women is through the Family Planning Program. The Family Planning program has service sites at the Women's Clinic, Rota Health and Tinian Health Centers, and offered via Mobile Clinic Outreach as well. The CNMI Family Planning Program provides a broad range of medically approved family planning services, which includes all Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods for clients such as:

- Pregnancy prevention and birth spacing,
- Pregnancy testing and counseling,
- Assistance to achieve pregnancy,
- Basic infertility services,
- Sexually transmitted infection (STI) services, and
- Other preconception health services.

Services are voluntary, confidential, and provided regardless of an individual's ability to pay. For many clients, the Family Planning clinic are their only ongoing source of health care and health education. In addition, the CNMI Family Planning Program provides other reproductive health and related preventive health services that are considered beneficial to overall women's health such as screening for breast and cervical cancer, hypertension, drug and alcohol use, sexually transmitted infections, intimate partner violence, etc.

Percentage of females age 18 – 44 years served by the CNMI Family Planning Program, 2016 – 2023

Year	2019	2020	2021	2022	2023
% Served	16.3	15.1	16.1	13.1	15.4
Numerator	1262	1164	1241	1004	1169
Denominator	7742	7721	7717	7641	7595

Data Source: CNMI Family Planning Annual Report

The Family Planning Annual Report (FPAR) is published annually to outline the reach of the program within the CNMI community and is used to inform analysis conducted by the MICAH programs regarding utilization of preventive health services. The Family Planning program is a key component for providing access to preventive health services within the women population in the CNMI. In 2023, the program served a total of 1,169 (15.4%) unduplicated number of women ages 18 through 44 years in the CNMI. The numerator value for this measure is gathered through program encounter data while the denominator is based on population projections made available by the US Census International Database. The report indicates an 18 percent increase in the number of women accessing care through CNMI Family Planning.

The MICAH programs also monitor the number of cervical cancer screenings or pap tests conducted in the CNMI. Data to inform this indicator is provided by the Diagnostic Laboratory Services (DLS) in Honolulu, where Pap specimens from the CNMI are processed (see table below).

Number of Pap Tests Conducted in the CNMI, 2016 – 2023

Year	2019	2020	2021	2022	2023
Number of Tests	**1,516**	**1,895**	**2,682**	**1,879**	**1,518**

Data Source: DLS Hawaii

In 2023, a total of 1,518 pap tests were processed by the DLS in Honolulu. There was a decrease of 361 pap tests conducted in 2023 compared to the year prior and 1,164 less than 2021, prior to the end of the Public Health Emergency and Medicaid Presumptive Eligibility.

Strategy: Provide community awareness regarding women's preventive health services.

The end of the Public Health Emergency allowed MICAH programs staff to focus on transitioning programmatic activities to pre-pandemic levels, increasing outreach activities and focusing on re-establishing many of the face-to-

face interventions that were temporarily placed on hold. In May of 2023, MICAH Programs partnered with the Community Guidance Center, the CNMI State Mental Health Agency, to coordinate the 2023 CNMI Mental Health and Women's Health Month. Community awareness activities and outreach events were conducted as part of efforts to engage the CNMI community in preventive health interventions. Events included live radio talk shows, mobile clinic outreach offering women's health services, healthy cooking/food demonstrations, as well as a women's health stakeholders meeting where MICAH programs updates and health data on CNMI women/maternal health with shared. Team members implemented a robust social media campaign where a total of 37 Facebook posts were published during CNMI Women's Health month with a reach of 65,559. Additionally, there were 614 likes and reactions and 112 posts that were shared.

Figure: 2023 CNMI Mental Health & Women's Health Month Calendar of Events

Women/Maternal Health - Application Year

Throughout the needs assessment process in 2020, women's health consistently was voiced as a priority and it became apparent that the recurring themes in this domain reflected the overall needs of the state. CHCC MICAH Programs have existing successful partnerships, resources and services and at an adequate position to provide more and engage community partners, build on existing programs, and address the needs of the state's woman/maternal population. The following actions are addressed in this priority: uniform screening, coordinated care, increased access to care through extended hours and additional locations, increased well woman visits, and understanding of preventive health coverage.

Activities to address priority areas identified during the 2020 comprehensive needs assessment for the Women/Maternal Health domain will continue to be guided by the life course framework. The priority selected for the next five-year cycle is focused on access to health services and the ability for women to find and see a doctor when needed. The MCH program will continue to work in partnership with clinical providers and partners to ensure activities to address this priority are implemented on the islands of Saipan, Tinian, and Rota

Additionally, MCH Title V will continue to collaborate with CHCC Mobile Clinic and Family Planning programs to conduct community outreach, bringing primary and preventive care services into hard-to-reach areas and to those who are having issues or challenges with transportation.

Priority need 1 for women's health is linked to National Performance Measure 1, in which annual reporting on the percentage of women ages 18 through 44 years who access preventive medical visits will be conducted.
Priority Need 1: Ability to find and see a doctor when needed (access to health services)

NPM 1: Percent of women, ages 18 through 44, with a preventive medial visit in the past year.

Objective: By 2025, increase the number of women who access preventive visits to 65%, a 10% increase from baseline.

Strategy 1: Expand preventive healthcare- Increase clinic hours or service sites.

For FY2025, the MCH program will work with CHCC Mobile Clinic and Family Planning program to increase the number of Women's health clinic outreach events, by utilizing the CHCC Mobile Clinic. Additionally, MCH will work with the CHCC Women's Clinic to establish monthly or quarterly women's health clinic outreach to the island of Tinian. Additionally, an additional Medical Assistant will be hired to support the increase in outreach clinics.

Year 5: October 2024 – September 2025

Activity	Lead Person	Measure/Evaluation	Timeframe
Meet with Women's Clinic Chairman and Mobile Clinic coordinator to identify providers and dates for Women's health outreach on the mobile clinic	MCH Services Coordinator, MICAH Administrator	Dates identified	October 2024
Meet with community partners to identify and secure outreach locations.	Mobile Clinic team	Mobile Clinic sites secured	October 2024
Hire/onboard a Medical Assistant to support increase in Women's health clinic outreach	Adolescent & Reproductive Health Manager, MICAH Administrator	Additional staff hired	November 2024
Conduct monthly outreach meetings to evaluate mobile clinic outreach activities.	Mobile Clinic team, MCH Title V Staff, Public Health Director	At least 10 meeting completed	October 2025

Evidence Based Strategy Measure (ESM) 1.1: Percentage of women accessing preventive health services at CHCC Clinics.

The measure that will be used to inform this strategy is ESM 1.1, percentage of women accessing preventive health services at CHCC clinic sites. Data to inform this ESM will be gathered through query of the CHCC CareVue electronic health record system. The program will assess the number and percentage increase in service utilization on a monthly basis among women/maternal population seen.

Strategy 2: Provide community awareness regarding women's preventive health services.

Community awareness activities will continue to be a vital component to activities conducted by the CHCC MICAH programs and is a main strategy for the CHCC organization in reaching community members. Social media, radio, and newspaper publications will be conducted to provide information and updates to the CNMI community. The MICAH Programs will work with the Public Health Promotions and Partnerships unit on community awareness campaigns to promote CNMI Women's Health, including activities during national women's health in May. To evaluate the impact of community awareness activities, the CNMI MCH will assess social media analytics, link event participation numbers to advertisements, and obtain data from newspaper and radio outlets on the number of viewers or listeners who accessed the information on women's health published.

Year 5: October 2024 – September 2025

Activity	Lead Person	Measure/Evaluation	Timeframe
Develop a schedule of Women's health topics to publish on social media, newspaper and radio	MICAH Health Promotions Specialist/Adolescent & Reproductive Health Manager	Schedule and topics finalized	October 2024
Publish social media, radio, and newspaper promotion materials	MICAH Health Promotions Specialist	Number of reach, views, shared	November 2024 – September 2025
Form a committee to plan for national Women's Health Week.	MICAH Administrator	Committee established and met	February 2025
Develop schedule of activities for national Women's Health Week	Women's Health week committee	Calendar of events published	April 2025
Conduct Women's Health week events	Women's Health week committee and partners	Number of participants in the events	May 2025

Updates in the MCH Title V block grant guidance for FY2025 includes a universal national performance measure for post-partum visits: A) Percent of women who attended
a postpartum checkup within 12 weeks after giving birth and B) Percent of women who attended a postpartum checkup and received recommended care components. In line with these changes the CNMI is adding objectives and strategies to address the new requirement.

NPM Postpartum visit: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth; B) Percent of women who attended a postpartum checkup and received recommended care components

Objective: By 2025, the CNMI will determine the baseline number of women who attended a postpartum checkup within 12 weeks after giving birth and the percent of women who attended a postpartum checkup and received the recommended care components.

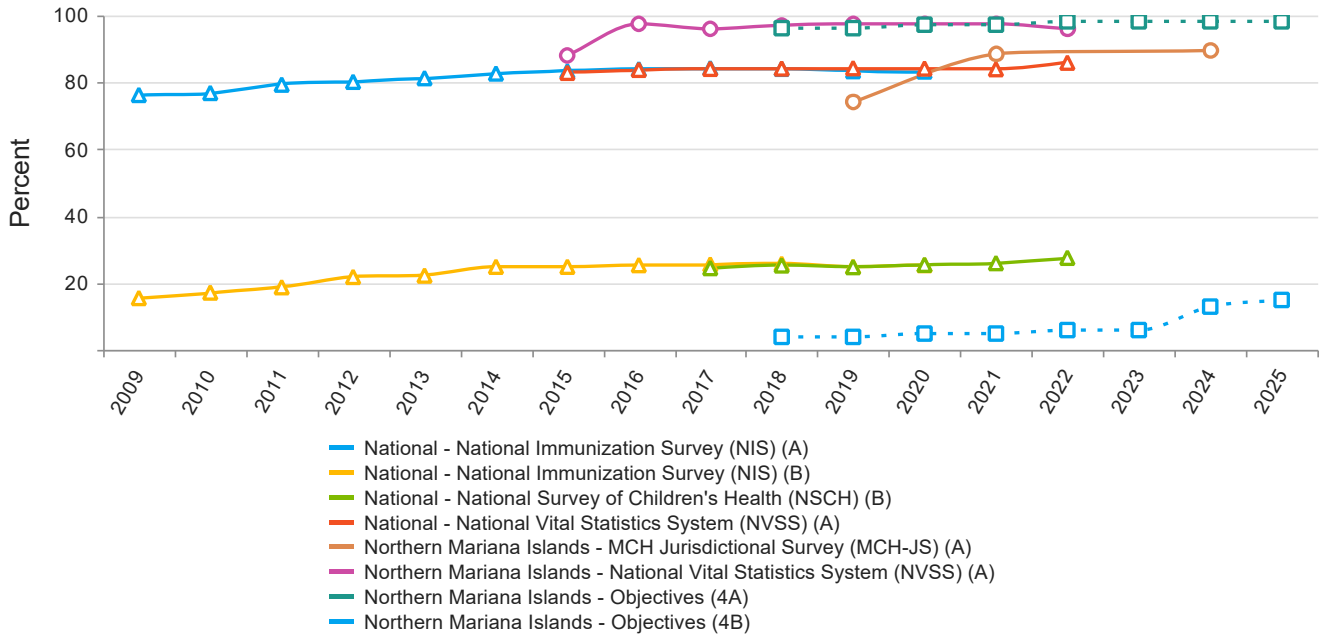
Strategy 1: Utilize the CNMI PRAMS data to identify the baseline number of women completing postpartum checkups and the percentage receiving recommended care components.

In FY 2025, the CNMI MCH Title V staff will work with the CNMI PRAMS project in analyzing CNMI PRAMS data to inform the NPM for postpartum visits. Baseline numbers and percentages will be identified through this strategy to inform planning and programming to address postpartum visit rates in the CNMI.

Perinatal/Infant Health

National Performance Measures

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF
Indicators and Annual Objectives



NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	96	97	97	98	98
Annual Indicator	74.2	74.2	88.2	88.2	89.4
Numerator	4,288	4,288	5,434	5,434	3,555
Denominator	5,776	5,776	6,158	6,158	3,976
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021	2024

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	98
Annual Indicator	95.7
Numerator	440
Denominator	460
Data Source	NVSS
Data Source Year	2022

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	96	97	97	98	98
Annual Indicator	96.5	93.3	93.7	94.9	93.1
Numerator	877	610	539	449	541
Denominator	909	654	575	473	581
Data Source	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	98.0	98.0

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

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

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	4	5	5	6	6
Annual Indicator	1.1	0.4	0	0.5	11.1
Numerator	5	2	0	2	47
Denominator	470	544	419	411	424
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Provisional

Annual Objectives		
	2024	2025
Annual Objective	13.0	15.0

Evidence-Based or –Informed Strategy Measures

ESM BF.1 - Percentage of WIC infants who were breastfed at 6 months.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10	57.4	57.6
Annual Indicator			44.6	39.9	43.2
Numerator			187	164	183
Denominator			419	411	424
Data Source			WIC Program	WIC Program	WIC Program
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	57.8	58.0

State Performance Measures

SPM 1 - Percent of live births to resident women with first trimester prenatal care.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	49	51	53	70	72
Annual Indicator	48.8	55.6	66.8	61.7	60.9
Numerator	340	351	382	290	327
Denominator	697	631	572	470	537
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	65.0	75.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Perinatal/Infant Health - Entry 1	
Priority Need	
Education and support to help with breastfeeding.	
NPM	
NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	
Five-Year Objectives	
By 2025, increase of the percentage of infants breastfed through 6 months to 54%, an increase from the baseline of 44%.	
Strategies	
Implement workplace breastfeeding policies/support	
ESMs	**Status**
ESM BF.1 - Percentage of WIC infants who were breastfed at 6 months.	Active
NOMs	
NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM	
NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal	
NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID	

State Action Plan Table (Northern Mariana Islands) - Perinatal/Infant Health - Entry 2

Priority Need

Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care

SPM

SPM 1 - Percent of live births to resident women with first trimester prenatal care.

Five-Year Objectives

By 2025, increase the number of pregnant women with first trimester prenatal Care to 75%, an increase from the baseline percentage of 55%.

Strategies

Provide service navigation for prenatal women

Perinatal/Infant Health - Annual Report

Based on the MCH Title V Block Grant guidance, the following annual report on infant health is based on activities during FY 2023 (October 01, 2022 through September 30, 2023). The CNMI MCH priorities around perinatal/infant health focus on improving breastfeeding rates and early prenatal care among pregnant women. Both breastfeeding and prenatal care were identified as priorities in the 2015 CNMI MCH Needs Assessment and selected again as priorities on the 2020 Needs Assessment.

The Public Health Emergency ended more than mid-way into FY2023, enabling MICAH Programs to transition back to pre-pandemic levels of activities. Strategies identified for FY2023 for improving infant health and addressing breastfeeding and prenatal care priorities included implementing workplace breastfeeding policies and support and providing service navigation for pregnant women.

The following report gives an overview and details on the NPMs and SPMs along with information on the activities completed in FY2023 to address the priorities of breastfeeding and early prenatal care as part of the infant health domain.

Priority: Education and Support for Breastfeeding
NPM 4A: Percent of infants ever breastfed.

Breastfeeding	2019	2020	2021	2022	2023
Percent of Infants	96.5	93.3	93.7	94.9	93.1
Numerator	877	610	539	449	541
Denominator	909	654	575	473	581

Source: CNMI HVSO, Birth Registry

The MCH Program gathers breastfeeding data to inform NPM 4A: Percent of Infants Ever Breastfed from the live birth registry out of the CNMI Health and Vital Statistics Office (HVSO). In 2023, 93.1 percent of live births in the CNMI were breastfed. There was a 1.8 percentage point decrease in this measure.
NPM 4B: Percent of infants breastfed exclusively through 6 months.

Exclusive Breastfeeding	2019	2020	2021	2022	2023
Percent of Infants	1.1	.4	0	.5	11.1
Numerator	5	2	0	2	47
Denominator	470	544	419	411	424

Source: CNMI WIC Program

For NPM 4B: Percent of infants breastfed exclusively through 6 months, the MCH program utilizes WIC

breastfeeding data to report on this measure. In 2023, there were 11.1 percent of infants met the criteria for breastfeeding exclusively through 6 months of age, a 2,120 percent increase in this measure. Activities that took place in FY2023 that contributed to these improvements included the hiring of a WIC Breastfeeding Peer Specialist and the development and implementation of a monthly quality assurance and performance improvement (QAPI) plan that enabled a more frequent and consistent review of breastfeeding status among WIC enrolled infants. The reviews provide the MICAH programs team an opportunity to evaluate monthly breastfeeding rates, identify potential strategies to implement for improving those rates, and evaluating impact of change strategies timely.

While breastfeeding initiation rates in the CNMI of 93.1 percent is higher than US national rate of 83.2 percent[i], the 6 months breastfeeding rate (43 percent) trails behind the US rate of 55.8 percent. However, it is important to note that the CNMI did experience improvements in both the breastfeeding and exclusive breastfeeding rates among 6 month old infants in 2023.

Strategy: Develop or strengthen prenatal clinic policies on breastfeeding education and counseling.
In FY 2023, MCH funds were used to procure breastfeeding supplies and breast pumps to enable direct support for postpartum women encountering challenges with breastfeeding. Lactation visits are offered through the CHCC Children's Clinic with medical provider, Dr. Heather Brook, IBCLC.

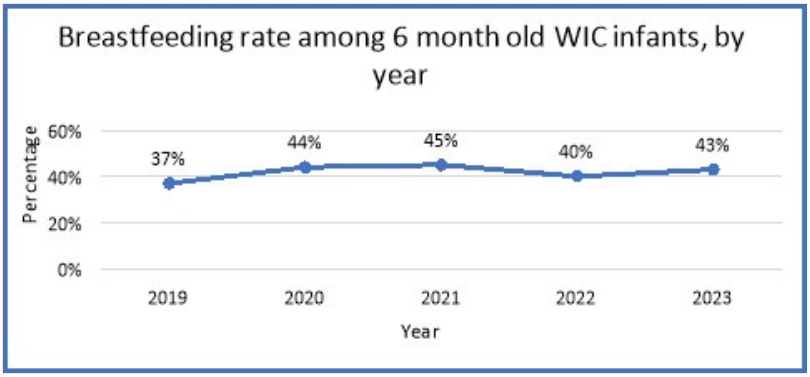
Others efforts in the prenatal clinic space that have been undertaken is the development of breastfeeding posters by MICAH programs promoting breastfeeding and including tips on latching along with contact information for accessing breastfeeding support in the CNMI.

In August of 2023, various Public Health Programs, including programs within the MICAH section partnered with the WIC program to coordinate community activities to promote breastfeeding as part of World Breastfeeding Week. Food demonstrations to support lactation, informational booths to promote the breast pump loaner program, as well as a road side waving to highlight the importance of breastfeeding were conducted.

The MCH program continues its partnership with the hospital nursery, NICU, and pediatrics units in supporting the breastfeeding needs of babies and their families who access hospital services. Breast pumps and breast pump kits available in these units continue to be supported by Title V funds. Additionally, access to donor breastmilk is made possible through Title V funds and made available as indicated to infants in the NICU.

The CNMI has identified the percentage of WIC infants being breastfed through 6 months of age as an evidence based/informed strategy measure for the perinatal/infant health domain. The WIC Program provides breastfeeding support and education to eligible families in the CNMI and the program has a wide reach among the infant population within the territory. The strategies being implemented and the work around breastfeeding in the CNMI is conducted in partnership with the CNMI WIC program. The WIC program in the CNMI has a tremendous reach within the perinatal/infant health domain and thus the MCH Title V efforts to increase breastfeeding rates in the CNMI are done in collaboration with WIC. The objective for this ESM is to increase the percentage of WIC infants being breastfed through 6 months of age to 58 percent by 2025.
Evidence Based Strategy Measure 4.1: Percentage of WIC infants breastfed through 6 months.

Figure 1. Breastfeeding Rates among CNMI WC infants, 2019 through 2023



Source: CNMI WIC Program

High breastfeeding initiation rates indicates that a vast majority of moms in the CNMI want to breastfeed and start out doing so. However, despite the recommendations for exclusive breastfeeding through 6 months, less than half (43 percent) of all 6 month old WIC infants in the CNMI are being breastfed.

Many factors contribute to success in continued breastfeeding and support to breastfeeding moms is critical.

Strategy: Implement workplace breastfeeding policies/support

Another strategy identified by the CNMI for improving breastfeeding rates is focused on workplace policies and support. This strategy was placed on hold for the duration of the public health emergency and thus in FY2023 the MCH Title V continues at the planning stage of this strategy. Strategy implementation is projected in FY2024.

Priority: Prevention of adverse infant outcomes through Prenatal Care

SPM 1: Percent of deliveries to resident women receiving prenatal care beginning in the first trimester of pregnancy.

Prenatal Care	2019	2020	2021	2022	2023
Percent	47.9	55	67	62	61
Numerator	334	347	382	290	327
Denominator	697	631	572	470	537

Data Source: CNMI HVSO

In 2023, 61 percent of non-tourist live births were to women who initiated prenatal care within the first trimester of pregnancy, a 1 percentage point decrease compared to the prior and still significantly higher than the 48 percent reported in 2019. Additionally, the CNMI preterm birth rate in 2023 was 10.5 percent and 10.5 percent of live births were identified as low birthweight, which indicate slight improvements in these outcomes compared to the 2022 preterm birth and low birthweight rates of 12.3 and 10.8 percent, respectively.

Strategy: Provide service navigation for pregnant women

In FY 2023, the MCH Title V funds were leverage to recruit a Community Health Worker (CHW) as part of efforts to

expand access to service navigation for pregnant women and infants seen through the CHCC Women's and Children's clinics. Service navigation includes assistance with completing Medicaid applications and expedited processing made possible through the memorandum of understanding between MCH Title V and the CNMI Medicaid program. Additionally, through service navigation, pregnant women are referred for prenatal dental cleaning at the CHCC Oral Health Program, enrollment into the CNMI MIECHV HOME Visiting Program, WIC, provided assistance with transportation to complete prenatal appointments, or connected to other community programs.

[i] Centers for Disease Control & Prevention. (2022). Breastfeeding Report Card, United States 2022. Retrieved on July 20, 2023 from https://www.cdc.gov/breastfeeding/pdf/2022-Breastfeeding-Report-Card-H.pdf

Perinatal/Infant Health - Application Year

The CNMI remains committed to the current work of promoting breastfeeding and prenatal care as a means of impacting infant health and throughout the life course. By strengthening existing partnerships with WIC program, MICAH Programs can continue to strengthen the guiding principle of collaboration and creating community change. Priorities identified for the CNMI Infant population are the prevention of adverse birth outcomes through Prenatal Care and Breastfeeding. These priorities continue from the previous 5-year cycle. The details below outline activities planned for FY 2025 (October 01, 2024 through September 30, 2025).

Priority need 2 is focused on improving the breastfeeding rates in the CNMI. This priority is aligned with national performance measure 4, percent of infants who are ever breastfed and the percent of infants breastfed exclusively through 6 months. The objective through 2025 is to increase the percentage of infants who are breastfed through 6 months to 54%, an increase from the baseline of 44%.

Priority Need 2: Breastfeeding

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

Objective: By 2025, increase of the percentage of infants breastfed through 6 months to 54%, an increase from the baseline of 44%.

Strategy: Implement workplace breastfeeding policies/support

In FY 2022, due to the COVID-19 pandemic, the MCH program was not able to conduct activities around workplace breastfeeding policies and support. Implementation work related to this strategy continued into FY 2023 and into FY2024. In 2023, the US Equal Opportunity Employment Commission (EEOC) issued its final regulation to carryout out the Pregnant Workers Fairness Act (PWFA), which went into effect on June 27, 2023. The PWFA required covered employers to provide reasonable accommodations to a qualified employees arising out limitations related to pregnancy, childbirth, or related medical conditions. The type of accommodations include schedule changes or time off to attend health care appointments, extra bathroom breaks, ability to telework full or part time, private place to pump breast milk, leave to recover from childbirth, and others. In FY2023, the CHCC Human Resource Department promoted the PWFA by putting up posters throughout the facility, sending email updates to all employees, and providing access to online webinars.

There are many factors that contribute to the CNMI's breastfeeding rates. Support for breastfeeding mothers in the workplace through workplace policies on breastfeeding is critical for women to sustain breastfeeding their infants at least until 6 months of age. There is evidence to suggest that working full-time outside of the home is related to a shorter breastfeeding duration. As mothers are one of the fastest growing segments of the labor workforce, we need to ensure that interventions are in place to support them and their infants.

In FY2025 of the CNMI MCH Title V will focus on working with 3 CNMI employers to implement or strengthen breastfeeding support and accommodations. The CNMI MCH Program will utilize the resources available in the Business Case for Breastfeeding toolkit available through the Office on Women's Health and language from the PWFA and the PUMP act to promote creating breast pumping spaces at worksites that are shielded from view, free

from intrusion, available as needed and not a bathroom.

For FY 2025, October 2024 through September 2025, the following activities provide an outline of the strategy that will be implemented for improving the percentage of babies breastfed through 6 months in the CNMI:

Workplace Breastfeeding Support

- Make enhancements/modifications or customize the existing workplace breastfeeding toolkit identified for use to support the workplace breastfeeding initiative.
- Partner with 3 businesses/employers (2 government agencies and 1 private employer).
- Conduct survey of workplace breastfeeding initiative participation to gather feedback on implementation process and identify opportunities for improvement.
- Publish Community awareness products and other messaging to promote the workplace breastfeeding initiative.

ESM 4.1: Percentage of infants breastfed through 6 months.

The program will assess infant breastfeeding rates at 3 and 6 months to determine whether the workplace breastfeeding supports strategy has had any impact on the CNMI breastfeeding rates. Other measures that will be assessed as part of this strategy are: number of employers who receive information or technical assistance from MICAH programs, number of employers who implement policies or recommendations provided in the CNMI workplace breastfeeding toolkit, and feedback/input from employers on the toolkit.

Priority need 3 is the prevention of adverse birth outcomes through prenatal care. In past years, the CNMI has had low percentage of live births to women accessing early prenatal care compared to the US mainland. This priority will be measured by state performance measure 1, percent of live births to resident women receiving prenatal care in first trimester of pregnancy. The objective for this priority was adjusted from increasing the percentage of live births with first trimester prenatal care to 75% from 65% by 2025. In 2022, the CNMI experience a decrease in the percentage of live births with first trimester prenatal care at 61.7 percent from 66.8 percent in 2021.

Priority Need 3: Prevention of adverse birth outcomes through Prenatal Care.

SPM 1: Percent of live births to resident women receiving prenatal care in the first trimester of pregnancy.

Objective: By 2025, increase the number of pregnant women with first trimester prenatal Care to 75%, an increase from the baseline of 55%.

Strategy: Provide service navigation for pregnant women.

The MCH Program will work on activities to increase the number of women who access MCH services for prenatal service navigation. Prenatal service navigation is intended to address barriers that prevent women from accessing prenatal care: lack of insurance or financial barriers to care, transportation, or others. Through service navigation, pregnant women will be screened for risk factors and offered support to access prenatal care, Medicaid or sliding fee assistance, preventive dental care, tobacco cessation services, WIC, and other community programs available. The MCH program will work with program partners to promote referrals and community awareness regarding early and adequate prenatal care.

There is moderate evidence that supports patient navigation as an effective intervention aligned with the percentage

of women accessing preventive healthcare.

For FY 2025, October 2024 through September 2025, the following activities provide an outline of the strategy of providing service navigation for pregnant women in the CNMI:

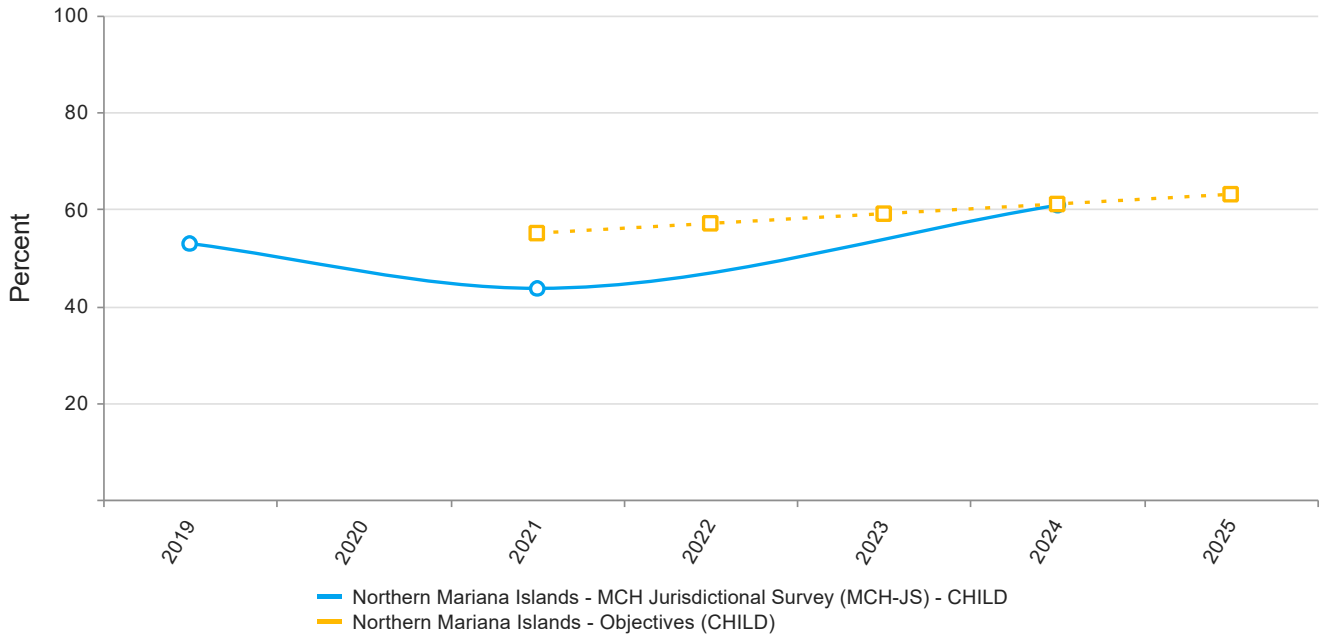
Service Navigation for Prenatal Women

- Promote early prenatal care and access to prenatal service navigation in the CNMI community through social media, radio and newspaper advertisements.
- Provide training to clinic staff at the Tinian Health Center and Rota Health Center on service navigation for pregnant women so that services are also available on those islands.
- Increase partnerships to strengthen identification and referral of pregnant women for service navigation by providing in-service training and community outreach.
- Partner with Family Planning to promote free pregnancy testing to identify pregnant women early and connect with service navigation when needed.

Child Health

National Performance Measures

NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child
Indicators and Annual Objectives



Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			55	57	59
Annual Indicator	52.7	52.7	43.5	43.5	60.7
Numerator	2,769	2,769	2,393	2,393	2,775
Denominator	5,253	5,253	5,498	5,498	4,572
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019	2021	2021	2024

Annual Objectives		
	2024	**2025**
Annual Objective	61.0	63.0

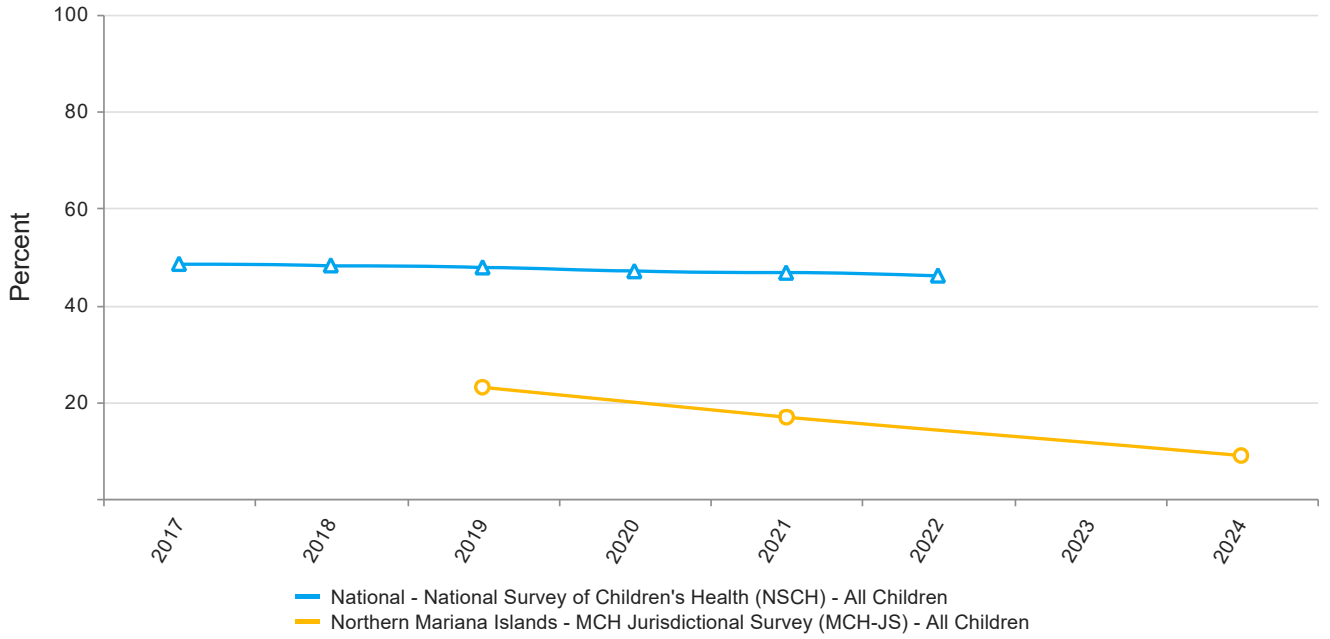
Evidence-Based or –Informed Strategy Measures

ESM PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10	15	20
Annual Indicator			0	0	25
Numerator			0	0	2
Denominator			3	8	8
Data Source			MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	25.0	30.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS) - All Children	
	2023
Annual Objective	
Annual Indicator	8.9
Numerator	1,208
Denominator	13,620
Data Source	MCH-JS-All Children
Data Source Year	2024

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			10	20	30
Annual Indicator			81	81	52.3
Numerator			51	51	45
Denominator			63	63	86
Data Source			F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	55.0	60.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Child Health - Entry 1	
Priority Need	
Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity	
NPM	
NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	
Five-Year Objectives	
By 2025, increase the percentage of children ages 6 through 11 years who report being active at least 60 minutes a day to 63%, an increase from the baseline of 53%.	
Strategies	
Increase the number of families who enroll in and evidence nutrition and physical activity programs.	
Increase community awareness on the importance physical activity for children.	
ESMs	**Status**
ESM PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.	Active
NOMs	
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	
NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS	

State Action Plan Table (Northern Mariana Islands) - Child Health - Entry 2

Priority Need

Helping parents/caregivers navigate the health care system for coordinated care

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

By 2025, increase the percentage of CSHCN who report having a medical home to 13%, an increase from the baseline of 9% in 2023.

Strategies

Partner with the CHCC Mobile Clinic to increase access to well child visits to connect children to medical homes.

ESMs	Status
ESM MH.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.	Active

NOMs

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

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Priority Need 4 is obesity related issues including nutrition and physical activity for the Child Health population in the CNMI. National performance measure 8, percent of children ages 6 through 11 years who are physical active at least 60 minutes per day is linked to priority need 4 and is being utilized by the CNMI Title V MCH program to measure progress or change in activities and outcomes for children in the CNMI. The data source for NPM 8 is the MCH Jurisdictional Survey, which was administered in the CNMI in 2019, 2021 and 2023.

Strategies identified to promote physical activity and overall health among children are focused on increasing the number of families who enroll in an evidence-based nutrition and physical activity program and increasing community awareness on the importance of physical activity among children.

In FY2022, the MCH program led efforts for establishing a partnership with the Northern Marianas College Expanded Food Nutrition Education Program (EFNEP) and implementing a referral process for families seen at the CHCC Children's Clinic to access an evidence-based nutrition and physical activity program available via EFNEP. However, in FY2023 the MCH program was notified by EFNEP of a pause of the program due to staff turnover. This also resulted in providers at the CHCC Children's Clinic suspending their referrals to EFNEP. In order to address the priority of obesity among children in the CNMI, the Division of Public Health utilized FY2023 to strategize and identify funding and recruitment of a Registered Dietician to help lead efforts around childhood obesity prevention within the territory. The Public Health Registered Dietician is projected to be onboarded by the end of FY2023.

Priority Need 4: Obesity related issues including nutrition and physical activity

NPM 8- Percent of children ages 6 through 11 years who are physically active at least 60 minutes per day.

Year	2020	2021	2022	2023
Percent	52.7*	43.5*	43.5*	60.7*
Numerator	2769	2393	2393	2775
Denominator	5253	5498	5498	4572

Data Source: 2019, 2021 & 2023 MCH Jurisdictional Survey
*Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

The data source for the NPM 8 is the MCH Jurisdictional Survey. For the 2020 reporting year, based on the survey conducted in 2019, it was estimated that 52.7 percent of children ages 6 through 11 years were physically active at least 60 minutes per day. The 2021 and 2022 reporting year utilizes data from the survey conducted in 2021 which estimates that the percentage of children ages 6 through 11 years who were physically active at least 60 minutes per day was 43.5. In 2023, the estimated percentage of children ages 6 through 11 years who were physically active at least 60 minutes per day was 60.7. There was a 17.2 percent increase in this indicator from the previous reporting year.

Strategy: Increase the number of families who enroll in an evidence-based nutrition and physical activity program.

Efforts to refer families seen by the Children's Clinic and Public Health programs to the EFNEP were suspended

due to challenges around EFNEP staffing turnover. Children's Clinic providers were concerned about sustainability of the strategy and there was worry about family frustration about their referrals not being addressed. In FY2023, Public Health leadership focused on securing funding to recruit a registered dietician to lead efforts around childhood obesity prevention in the CNMI. Funding was approved and a registered dietician identified to fill the role. Onboarding of the Public Health registered dietician is projected by the end of FY2024.

Evidence Based Strategy Measure 8.1

ESM 8.1 reports on the percentage of referrals to EFNEP that completed at least 75 percent of the curriculum sessions. In FY2023, there were a total of 85 referrals to EFNEP prior to the referrals being suspended. Two out of the 8 referrals completed at least 75 percent of the program. This ESM will be revised to align with the change in strategy to address obesity, nutrition and physical activity among CNMI children.

Strategy: Increase community awareness on physical activity for children.

In FY2023, efforts to increase physical activity among children in the CNMI were led by the Non-Communicable Disease Programs staff under the Division of Public Health. The Healthy Communities unit of NCD programs organized "Sports Clinics" throughout the various villages on the island of Saipan as part of efforts to introduce various sports activities as a method for engaging CNMI youth in physical activity. Some of the Sports Clinic events included: volleyball, basketball, frisbee, and even sailing. The CNMI MCH Title V helped to promote these clinics among clients served as well as throughout the community via social media. The NCD Healthy Communities unit reported 375 participants during Sports Clinic events in FY2023.

Other Child Health Activities

MCH Title V continued to support activities to promote increasing the rate of children completing annual preventive visits and vaccinations. Well-child visits provide children the opportunity to receive preventive screenings and anticipatory guidance on nutrition and physical activity from trusted medical professionals. MICAH Programs staff promoted well-child serviced available via the CHCC Mobile Clinic. A total of 18 Well-Child outreach clinics were conducted in FY2023 reaching 171 children ages 0-19 years of age. Additionally, in partnership with the Public School System (PSS) a total of 25 school-based vaccination clinics providing routine pediatric vaccinations to CNMI children in FY2023.

Child Health - Application Year

Discussions during the 5-year needs assessment process regularly focused on the need to address obesity across population domains but beginning at an early age. While there was targeted discussion about children, specifically related to obesity, there was a shift to a broader view of the systemic nature of nutrition and physical activity.

Specifically, a change in terminology and definition began to emerge and the priority was reframed. Providing access to healthy food choices and safe physical activity was an issue of both availability and knowledge. The need to educate parents and children on what constitutes a healthy food choice was clearly reflected in the data. At the same time, the real challenge caused by affordable and healthy food in CNMI was discussed.

Some families rely on small convenience stores due to transportation barriers and/or locale, thus connecting other daily issues (poverty, work schedules, children home alone) to unhealthy food choices. Physical activity is impacted by community issues related to neighborhood planning and development and transportation barriers to organized sports.

Issues identified in the 2020 MCH Needs Assessment are further impacted by the effects of the COVID-19 pandemic. Stay at home measures, closure of various businesses including establishments that offer opportunities for physical activity (swim parks, skating rinks, parks, etc.), and schools shifting to virtual learning had tremendous effects on access to physical activity opportunities. According to the Centers for Disease Control and Prevention (CDC), in a study of 432,302 children ages 2 through 19 years, it was found that the rate of body mass index (BMI) increase nearly doubled during the COVID-19 pandemic compared to the pre-pandemic period. Additionally, the rate increase was more pronounced in children identified as overweight or obese and among younger school-aged children[1].

Promoting healthy weight during childhood is crucial in leading into optimal health in adulthood. The CNMI has identified the priority need of obesity related issues including nutrition and physical activity, as it has been identified high risk among our children, leading into complex health issues. Establishing healthy nutrition and physical activity habits early in life will be crucial to prevent further complex health issues caused by risk factors of overweight and obesity.

CNMI MCH priority need 4 is obesity related issues including nutrition and physical activity. This priority is aligned with national performance measure 8, percent of children ages 6 through 11 years who are physically active at least 60 minutes per day. The CNMI objective for this priority need and measure is to increase the percentage of children ages 6 through 11 years who report being active at least 60 minutes a day to 63% by 2025.

Priority Need 4: Obesity related issues including nutrition and physical activity

NPM 8- Percent of children ages 6 through 11 years who are physically active at least 60 minutes per day.

Objective: By 2025, increase the percentage of children ages 6 through 11 years who report being active at least 60 minutes a day to 63%, an increase from the baseline of 52.7%.

Strategy: Increase the number of families who enroll in and evidence nutrition and physical activity program.

In FY2025, MCH Title V funds will be used to support sports clinics that will be offered on the weekends for expanding access to opportunities to engage in exercise and physical activity for children in the CNMI. The sports clinic initiative is led by the CHCC Public Health Non-Communicable Disease Programs and began in FY 2023.

Additionally, in FY2024, Public Health Services recruited a Registered Dietician to lead the implementation of nutrition focused prevention activities. MCH Title V funds will be used to support increasing access to evidence based nutrition activities that will be made available through the support of the newly recruited Public Health Registered Dietician.

From October 2024 through September 2025, the following activities provide an outline of the strategy that will be implemented for increasing the number of children and families participating in nutrition education and physical activity:

- Support the Public Health Non-Communicable Disease Programs to identify community partners to engage in sports clinic planning and nutrition education programming
- Work with community partners to develop a monthly calendar of sports clinic events and nutrition education sessions
- Promote sports clinics and nutrition education programming in the CNMI
- Conduct a monthly meeting or provide monthly updates to community partners on sports clinics and nutrition education outcomes, attendance/participation rates.
- Conduct post event or post session evaluations to gather input or feedback from community members for improving the quality and impact of physical activity and nutrition focused programming.

ESM 8.1: Number of children who participate in sport clinic events in the CNMI.

To measure the impact of the strategy on the priority area and objective, the MCH program will collect information on the number of children ages 6 to 11 years old in the CNMI who participate in physical activity via the sports clinics that will be implemented.

Strategy: Increase community awareness on the importance physical activity for children.

The MCH program will utilize communications and marketing strategies to educate the community, most especially parents and caregivers, on the importance of physical activity for children. Print, radio, video, and social media advertisements will be utilized to promote the monthly sports clinics as well as nutrition education sessions that will be coordinated via Public Health. Additionally, the program will partner with community agencies to disseminate the information materials developed to families that are served by the various partners. The MICAH Programs will work closely with the Public Health Non-Communicable Disease Program to align strategic activities and efforts to address childhood obesity and promote nutrition education and physical activity.

For FY 2025, the following activities provide an outline of the strategy that will be implemented for increasing community awareness on the importance of physical activity for children:

Advertisements and Promotions

- Develop, revise and finalize social media advertisements, TV commercial content, radio scripts, and newspaper content layout.
- Develop a consistent scheduled and structured dissemination of public education and awareness

advertisements and publications.
- Monitor and evaluate reach and effectiveness of the advertisements and promotions activities.

Updates to the MCH Title V block grant guidance for FY2025 includes a universal national performance measure for percent of children with and without special health care needs, ages 0 through 17, who have a medical home. The CNMI currently has the NPM for Medical Homes selected under the CSHCN domain and is now adding this measure under the Child health domain in line with the new guidance.

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

Objective: By 2025, increase the percentage of children who report having a medical home to 17%, an increase from the baseline of 9% in 2023.

Strategy: Partner with the CHCC Mobile Clinic to increase access to well child visits to connect children to medical homes.

In FY2025, MICAH Programs will work with the CHCC Mobile Clinic to increase the number of well-child outreach clinics as a mechanism for expanding access to primary preventive care services and connecting children and their families to medical homes.

For FY 2025, the following activities provide an outline of the strategy for increasing well child visits through the mobile clinic:

- Work with the CHCC Mobile clinic to develop a schedule of recurring monthly well child visits in various village community locations
- Engage partners who serve the child population in supporting referrals and to promote mobile clinic events to their clients
- Promote mobile clinic outreach events on social media, radio, and newspapers.

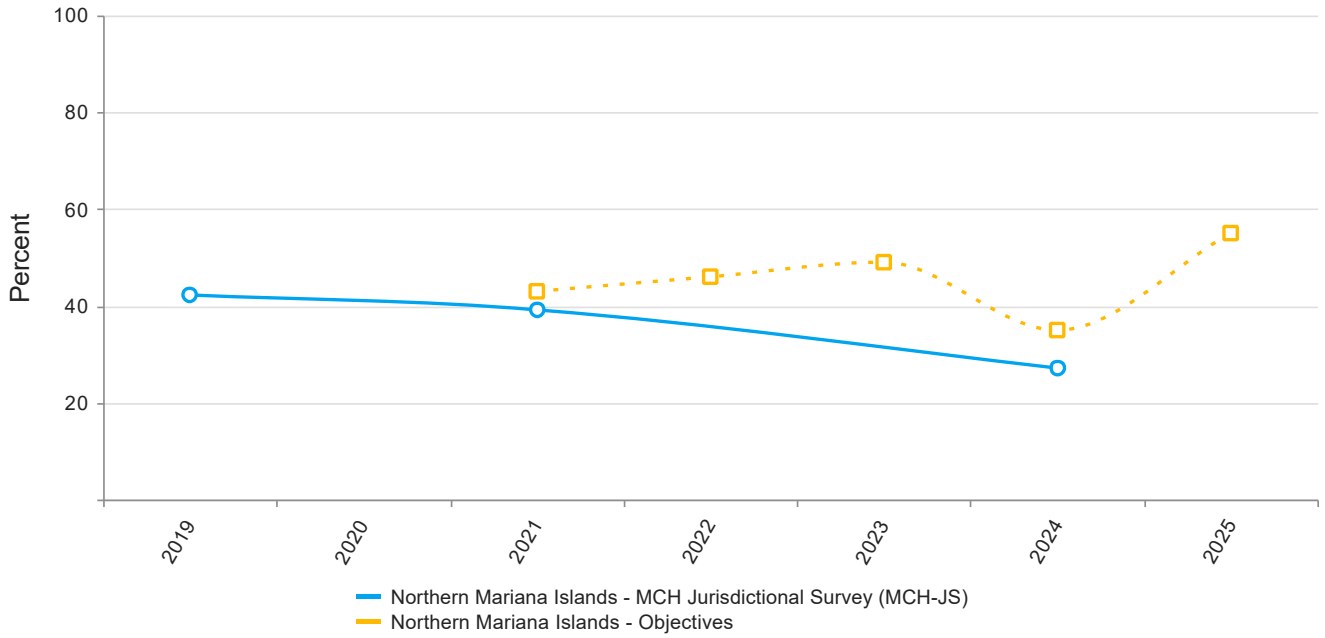
[1] Centers for Disease Control and Prevention (CDC). (2022). Children, Obesity, and COVID-19. Retrieved on July 29, 2022 from https://www.cdc.gov/obesity/data/children-obesity-COVID-19.html#:~:text=A%20study%20of%20432%2C302%20children,and%20younger%20school%2Daged%20children.

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Indicators and Annual Objectives



Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			43	46	49
Annual Indicator	42.4	42.4	39.3	39.3	27.3
Numerator	2,593	2,593	2,156	2,156	1,386
Denominator	6,119	6,119	5,493	5,493	5,072
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021	2024

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			43	46	49
Annual Indicator	18.8	8.1	22	12.1	
Numerator	1,143	503	1,378	749	
Denominator	6,094	6,215	6,256	6,177	
Data Source	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	35.0	55.0

Evidence-Based or –Informed Strategy Measures

ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			10	1	12.5
Annual Indicator			22	12.1	16.6
Numerator			1,378	749	998
Denominator			6,256	6,177	5,994
Data Source			CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	17.0	19.0

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR
Indicators and Annual Objectives

NPM TR - Adolescent Health - All Adolescents

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - All Adolescents					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			55	55	55
Annual Indicator	48.4	48.4	46.3	46.3	39.6
Numerator	2,788	2,788	2,306	2,306	2,006
Denominator	5,761	5,761	4,982	4,982	5,072
Data Source	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN	MCH-JS-All Adolescents	MCH-JS-All Adolescents	MCH-JS-All Adolescents
Data Source Year	2019	2019	2021	2021	2024

Annual Objectives		
	2024	**2025**
Annual Objective	51.0	61.0

Evidence-Based or –Informed Strategy Measures

ESM TR.1 - Percentage of high school students served by SPED who received information on transition

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10	15	20
Annual Indicator			0	4.9	34.4
Numerator			0	16	115
Denominator			322	329	334
Data Source			Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	35.0	37.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Adolescent Health - Entry 1	
Priority Need	
Coping skills and suicide prevention	
NPM	
NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	
Five-Year Objectives	
By 2025, increase the percentage of adolescents who access well visits to 55%, an increase from the baseline of 42%.	
Strategies	
Partner with the Public School System to increase the number of adolescents accessing adolescent health visits.	
ESMs	Status
ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites	Active

NOMs

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

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

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

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

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

State Action Plan Table (Northern Mariana Islands) - Adolescent Health - Entry 2

Priority Need

Helping parents/caregivers navigate the health care system for coordinated care

NPM

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR

Five-Year Objectives

By 2025, increase the percentage of adolescents ages 12 through 17 years with and without special healthcare needs who receive transition services to 74% and 61%, respectively, an increase from baseline percentages of 51% and 48%, respectively.

Strategies

Provide education, presentations, and support to high school students and/or their parents in making transition into adult healthcare.

ESMs	Status
ESM TR.1 - Percentage of high school students served by SPED who received information on transition	Active

NOMs

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

Adolescent Health - Annual Report

Activities identified in this reporting period for the MCH Title V Block Grant reflect the FY2023 (October 01, 2022 – September 30, 2023). The MCH Title V project aimed to implement activities to provide support and education, promote healthy behaviors and transitional care, and increase engagement in adolescents accessing health care services. As with many of the other domain areas, the CNMI MCH Title V program leverages its robust partnerships with agencies such as the CNMI Public School System (PSS) to reach a large segment of the population, develop plans for activities, and monitor prevalent factors that impact adolescent health. The MICAH Programs continues to maintain such partnerships and form new partnerships to address the needs of adolescents.

One of the priority needs identified during the 2020 CNMI MCH comprehensive needs assessment process for the adolescent population was coping skills and suicide prevention. This priority need was aligned with National Performance Measure (NPM) 10, percent of adolescents ages 12 through 17 years with a preventive medical visit in the past year. The MCH program works to promote well visits for adolescents at which a holistic approach to conduct a behavioral health screening and assessment as part of the well-visit aims to encourage healthy coping skills and preventing suicide. In addition, priority need 7 has been identified by the MCH needs assessment as an area of focus for adolescents with and without special healthcare needs, which is to support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful. Priority need 7 is aligned with National Performance Measure (NPM) 12, percent of adolescents with and without special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care.

In the reporting period (FY 2023), the CNMI PSS resumed full-time, in-person instruction for all public schools in the jurisdiction. Since the unwinding of the Public Health Emergency and regaining normalcy after the COVID-19 pandemic, the CNMI PSS provided the opportunity for the Public Health programs to resume school-based outreach activities such as classroom presentations and clinical service outreach.

In partnership with the CNMI PSS, the programs worked to increase vaccination rates as a strategy to ensure kids had access to safe learning environments and protection from severe disease as they transitioned back to in-person learning instruction. COVID-19 vaccination outreaches were conducted at schools, community centers in the various villages, and on the CHCC Mobile Clinic. Gift certificates to fuel or groceries were utilized as incentives to motivate teens and their families to get vaccinated. In effort to maximize outreach events, programs ensured that vaccine providers were assessing for and co-administering other routine vaccinations that may also be due for teens. This was critical for maintaining high coverage rates for vaccines like HPV and Tdap among the adolescent population.

As part of preparation for the School Year 2022 – 2023, the MICAH leadership-initiated planning meetings and implementation assessments to conduct outreach in the schools. During this reporting period, the Public Health Services programs including the MICAH Programs and Non-Communicable Disease (NCD) Programs, had developed the teen health outreach presentations and participated in trainings to conduct basic health screenings in the schools to provide service outreaches. Basic health screenings include glucose checks, blood pressure monitoring, Body Mass Index (BMI) measurements, interpretation of screening levels, and referrals and assistance in accessing adolescent well visits. The outreach initiative was piloted with two high schools on the island of Saipan in School Year 2022-2023 and will be expanded to all CNMI high schools during the following school year (FY2024).

In FY 2023, the CNMI MCH Title V staff actively engaged in the CNMI Pediatric Mental Healthcare Access (PMHCA) project advisory committee. The CNMI PMHCA Program is focused on establishing access to psychiatric consultation, coordination and support, and provider training to support CNMI pediatric and adolescent primary and preventive care providers. This work will improve adolescent preventive medical visits strengthening and/or

integrating screening for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues.

Priority Need 5: Coping Skills and Suicide Prevention

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

Adolescent Well-visits	2020	2021	2022	2023
Percent	42.4	39.3	39.3	27.3
Numerator	2,593	2,156	2,156	1,386
Denominator	6,119	5,493	5,493	5,072

Data Source: CNMI MCH Jurisdictional Survey

Data gathered on teen well visits through the MCH Jurisdictional Survey conducted in the CNMI indicates a 12 percentage point decrease in the percentage of CNMI teens accessing preventative health care compared to the prior reporting year, 2022.

Strategy: Partner with the Public School System to increase the number of adolescents accessing adolescent health visits.

Increasing the number of teens that access wellness visits is intended to increase the number of teens who are screened by medical professionals for potential behavioral concerns, and connected to appropriate services that address coping skills and suicide prevention. During the reporting period, the MICAH Programs and the NCD Programs conducted several classroom presentations at the local middle and high schools on Saipan. The presentations covered topics such as the importance of teen wellness visits and its various components. Education on confidential teen health services available via the Family Planning program was also presented. Furthermore, the high school students were able to participate in school-based clinic outreach scheduled during the School Year 2022 – 2023. The opportunity provided students access first-hand basic preventive screening services, such as screening for diabetes and hypertension. The outreach events also offered teens access to information about other services and partner organizations who work with adolescents in the CNMI. This strategy also helps the MCH program in early identification of youth at risk for chronic diseases and provide the necessary referrals to the appropriate health care services.

Evidence Based Strategy Measure 10.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites

Year	2021	2022	2023
Percentage	22.0	12.1	16.6
Numerator	1378	749	998
Denominator	6256	6177	5994

The ESM used to track progress relating to strategies implemented to achieve goals and objectives for CNMI adolescent is the percentage of teen 12 through 17 years accessing preventive services at the CHCC sites. According to the US Census international database estimates, there were 5,994 adolescents ages 12 through 17 years in the CNMI in 2023. There were 998 adolescents in the CNMI who accessed preventive care via CHCC in

2023. While there is a 4.5 percentage point increase in this measure in 2023 compared to 2022, it is still lower than the percentage in 2021 where the CNMI reported 22 percent.

In FY2023, through a partnership with the CHCC Children's Clinic and Public School System, the MICAH Programs provided diabetes and hypertension screening and prevention education outreach at 2 out of the 6 CNMI public high school campuses. A total of 291 teens completed preventive screenings as part of the school-based outreach efforts. Teens identified with concerning glucose and blood pressure rates are provided assistance in obtaining an appointment with a pediatrician at the CHCC Children's Clinic. The Children's Clinic team offered reserved appointments slots to support the outreach and for the event that a teen needed to obtain an immediate clinic visit to address potential health conditions identified during the outreach. There were a total 21 referrals made to the Children's Clinic and MCH provided service coordination to ensure students completed a follow-up visit with a pediatrician.

Moreover, it should be noted that over recent years, the CNMI has noted increases in the number of teens within the age group (12 through 17) accessing Family Planning services and increases in male teens being served. In 2023, there were 108 teens reported to have accessed family planning services, which is higher compared to years prior to the COVID-19 pandemic (2019, 82 teens accessed family planning). The number of male teens accessing family planning services has also been on the rise. In 2023, there were 4 male teens reported to have accessed family planning services, compared to 2019 when there were no male teen participants. The MICAH programs have been working diligently to ensure access to confidential adolescent health services is sustained.

Priority Need 7: Support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful.

NPM 12-B: Transition- Percent of adolescents without special healthcare needs, ages 12 through 17 years, whose families report that they received services necessary to make transitions into adult health care.

Transition (Non-CSHCN)	2020	2021	2022	2023
Percent	50.1	41.7	41.7	39.6
Numerator	2,971	1,886	1,886	2,006
Denominator	5,927	4,518	4,518	5,072

Data Source: CNMI MCH Jurisdictional Survey

Based on data through the MCH Jurisdictional Survey conducted in the CNMI, 39.6 percent of adolescents without special healthcare needs ages 12 through 17 years, received services necessary to make transitions into adult healthcare in 2023. Compared to the previous year, there was a slight decrease in the number of teens whose families reported that they received transitional services.

Strategy: Provide education, presentations, and support to high school students in making transition into adult healthcare.

Similar to strategy 1 in the adolescent health domain, strategies to increase the percentage of teens ages 12 through 17 years that receive transition services focused on leveraging the existing partnerships the CHCC and MICAH programs had with the Public School System. During the reporting period, the partnership initiated the development of plans and strategies to address the priority need. Since the transition of classroom instruction back to in-person learning, and with the start of a new partnership between MICAH Programs and the Providers and Teens Communicating for Health (PATCH) Program; the activities related to this strategy were carried into FY2024 plans.

Other Adolescent Health Activities

In FY 2022-2023, the MICAH programs began working closely with the CHCC Children's Clinic department on tracking the number of teens that complete preventive well-visits as referred by the CNMI PSS outreach activities. As part of monthly quality improvement efforts within the Division of Public Health Services, MICAH Programs monitor the number of teens visits to support data-driven decision making, and to inform interventions for improving teen well-visit rates.

In an effort towards improving staffing capacity to support the MCH Title V workplan activities for the adolescent health domain, the MICAH unit began recruitment for an Adolescent and Reproductive Health Manager in 2022. Hiring for this position was completed in February 2023. The incumbent is responsible for overseeing the implementation of workplan activities and monitoring of progress in meeting goals and objectives relating to the adolescent health domain.

Additionally, the MICAH Programs was awarded a funds by the Association of Maternal & Child Health Programs (AMCHP) to replicate the Providers and Teens Communicating for Health (PATCH) Program in the CNMI. The PATCH Program is an evidence-based program that aim to improve adolescent health and wellbeing by working with youth to advocate for adolescent health care rights, responsibilities, and healthy relationships. In anticipation to carry out program activities for FY 2024, MCH developed partnership with the CNMI Division of Youth Services (DYS) and formalized partnership through a Memorandum of Understanding. During the reporting period, the MICAH Programs coordinated with the PATCH Directors and DYS to complete a proposed timeline of activities and participate in the PATCH Coordinators Training.

Adolescent Health - Application Year

Improving adolescent health continues to be priority across Public Health programs multiple partners collaborating on activities. The MICAH Programs maintains an important partnership in addressing adolescent health with the CNMI Public School System (PSS). Together, MCH and PSS will continue to work together on developing plans and implementing activities to most effectively address the needs of the adolescent population.

Our Public School System has direct contact with a vast majority of the adolescent population in the CNMI. Therefore, utilizing a school-based approach to providing preventive programs outreach and information is an ideal strategy. As a public health focus, preventing risky behaviors in childhood and adolescence is less challenging when compared to trying to change unhealthy behaviors in adulthood. MCH will continue its efforts towards improving adolescent health by focusing on the priorities of improving transition services and promoting coping skills and suicide prevention among teens.

Promoting positive coping mechanisms can be accomplished by educating students and performing annual mental health screenings, which supports suicide prevention efforts and addressing bullying/ bullies. Preventative health well visits for adolescents, which are fully covered under public health insurance (i.e. Medicaid), promotes overall physical health (immunizations, healthy eating, and oral health), as well as social-emotional health (self-awareness, coping skills, managing stress). Social-emotional health can also be strengthened by trained adults and mentors helping adolescents navigate life skills and set goals (high school completion, employment, healthy relationships). Given that adolescents have a natural desire to become active agents in society and community, this priority can be promoted through community partnerships and engagement and can reinforce protective factors and promote prevention of risky behaviors.

Based on the MCH Needs Assessment, Priority need 5 is identified as a primary focus on adolescent coping skills and suicide prevention and linked to National Performance Measure (NPM) 10: the percent of adolescents ages 12 through 17 years with a preventive medical visit in the past year. The objective for the CNMI MCH is to increase the percentage of adolescents who access well visits to 55%, an increase from the baseline of 42%. Increasing the percentage of teen accessing well-visits will also increase the number of teens who are accessing preventive healthcare as well as screenings, information, and access to behavioral health services for social-emotional and behavioral health needs.

Priority Need 5: Coping Skills and Suicide Prevention

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

Objective: By 2025, increase the percentage of adolescents who access well visits to 55%, an increase from a baseline of 42%.

Strategy: Partner with the Public School System to increase the number of adolescents accessing preventive visits.

The MICAH Programs will continue to collaborate with the CNMI PSS to conduct on-campus health screenings focused on engaging teens in the local high schools on preventive care visits. In partnership with CNMI PSS, Public Health staff will conduct classroom presentations educating students on the importance of preventive checks, chronic disease prevention, and sexual and reproductive health. In addition to the classroom presentations, the CHCC Mobile Clinic will be utilized to provide preventive care services and screenings at the high schools on Saipan.

Students will have the opportunity to receive screening services such as glucose screening, blood pressure screening, and family planning services. Screening results will be interpreted and trained screeners will educate students on practices to maintain healthy levels. Students identified with potential health risks based on their screening results will be referred for follow-up care through the CHCC Children's Clinic. The MCH Services Manager provides service coordination working with pediatric providers to ensure that students identified needing follow-up are seen by a pediatrician.

Conducting outreach through this mechanism increases students' awareness of accessible health care services and provides information to share with their parents regarding adolescent well visits and support for accessing them. This project aims to reach approximately 40% of the targeted high school population to provide information and education regarding healthy lifestyle behaviors. The MICAH programs will work to expand the activities to all public high schools in the CNMI in FY2025.

For FY 2025, October 2024 through September 2025, the following activities provide an outline of the strategy in partnering with the school system to identify and refer adolescents to well-visits:

School Partnership to Identify and Refer for adolescent well-visits:

- Partner with the CNMI PSS to develop an outreach schedule for school-based presentations, screenings, and referrals for accessing adolescent well visits
- Expand outreach and screenings to include more public high schools
- Procure needed screening and outreach supplies
- Utilize survey data gathered from previous outreaches to improve and update outreach presentation materials
- Complete all scheduled outreach events
- Evaluate the outreach and referral process
- Complete a report and present outreach outcomes and evaluation results to key stakeholders

ESM 10.1: Percentage of adolescents accessing preventive care through referrals from the Public School System (PSS)

To measure the impact of the strategy on the priority area and objective, the MCH program will report on the percentage of students referred to adolescent well visits during high school outreach events. Additionally, the MICAH programs will work with the CHCC Children's Clinic to monitor the number of teens completing well visits at the clinic and identify trend changes in the number and percentage of adolescent well visits being conducted each month.

Priority need 7: support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful. This priority is aligned with National Performance Measure (NPM) 12, percent of adolescents with and without special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care. The objective around this priority and measure is to increase the percentage of teens without special health care needs who receive transition services to 64% by 2025.

Priority Need 7: Support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful.

NPM 12: Transition- Percent of adolescents with and without special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care.

Objective: By 2025, increase the percentage of adolescents ages 12 through 17 years with and without

special healthcare needs who receive transition services to 74% and 61%, respectively, an increase from baseline percentages of 51% and 48%, respectively.

Strategy: Provide education, presentations, and support to high school students and/or their parents in making transition into adult healthcare.

In FY2023, the CNMI MCH Title V Program successfully secured funding through the Association of Maternal and Child Health Programs (AMCHP) to replicate the Providers and Teens Communicating for Health (PATCH) program in the CNMI. The project will be implemented in partnership with the CNMI Division of Youth Services (DYS) and will contribute to the strategies identified in the MCH work plan for adolescent health.

The PATCH program toolkit is composed of two workshops: PATCH for Teens and PATCH for Providers. PATCH for Teens aims to improve the way adolescents' access, receive, and experience health care by teaching teens their health care rights, responsibility to manage their own health, and the importance of developing a trusting relationship with their health care provider. PATCH for Providers aims to inform adolescent serving health care staff and providers how to develop a trusting relationship with their adolescent patients, as well as how to teach adolescents the importance of health care rights and responsibilities. In addition, the PATCH program toolkit for parents will be utilized to conduct presentations with Parent Teacher Associations, and is intended to engage and educate parents, guardians, or caregivers on teen rights and responsibilities in accessing health care services, and how to support teens in managing their own health.

For FY 2025, October 2024 through September 2025, the following activities provide an outline of the strategy in for providing transition services and information to adolescents in the CNMI:

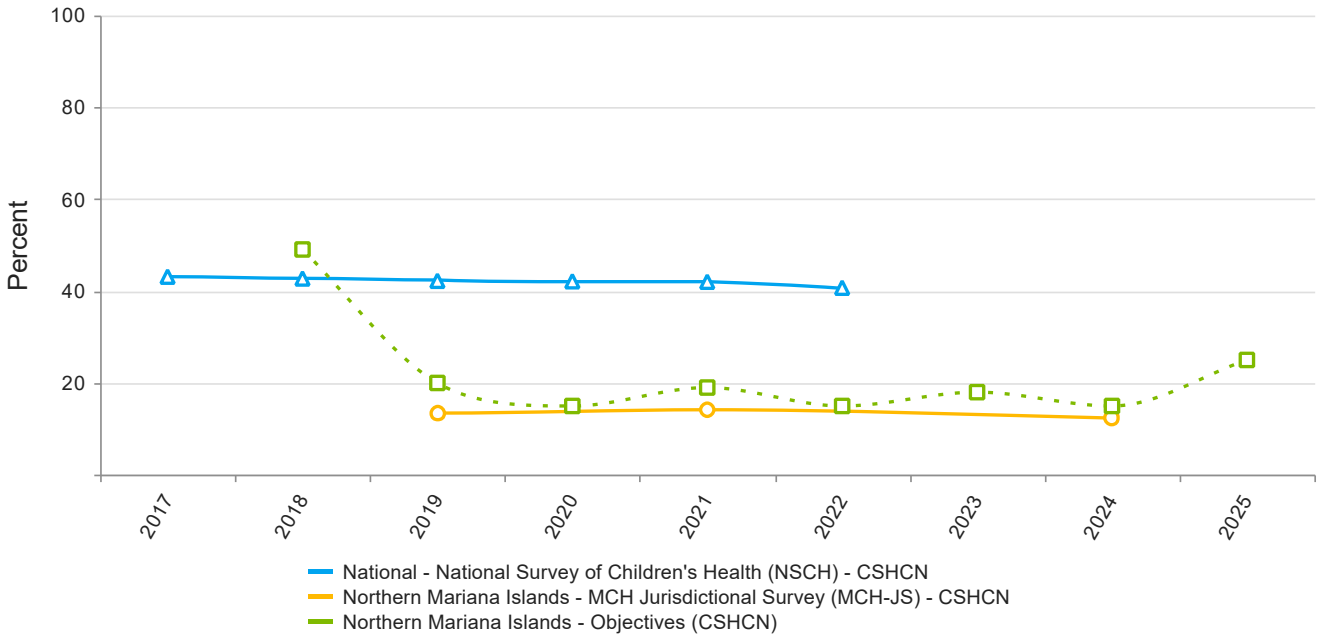
Transition Services Presentations

- Develop presentations utilizing information available via Got Transitions and PATCH program toolkit.
- Partner with the school system and Parent Teacher Association to develop a schedule for presentations
- Conduct presentations with youth agencies and organizations, high school students, and peer groups
- Implement transition assessments for youth and parents of youth during presentation sessions
- Gather feedback/ input on presentations to evaluate effectiveness of information delivery and identify areas of improvement.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	20	15	19	15	18
Annual Indicator	13.3	13.3	14.1	14.1	12.5
Numerator	141	141	176	176	138
Denominator	1,059	1,059	1,252	1,252	1,101
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021	2024

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	20	15	19	15	18
Annual Indicator	19.6				
Numerator	54				
Denominator	276				
Data Source	CSHCN Survey				
Data Source Year	2019				
Provisional or Final ?	Provisional	Provisional			

Annual Objectives		
	2024	2025
Annual Objective	15.0	25.0

Evidence-Based or –Informed Strategy Measures

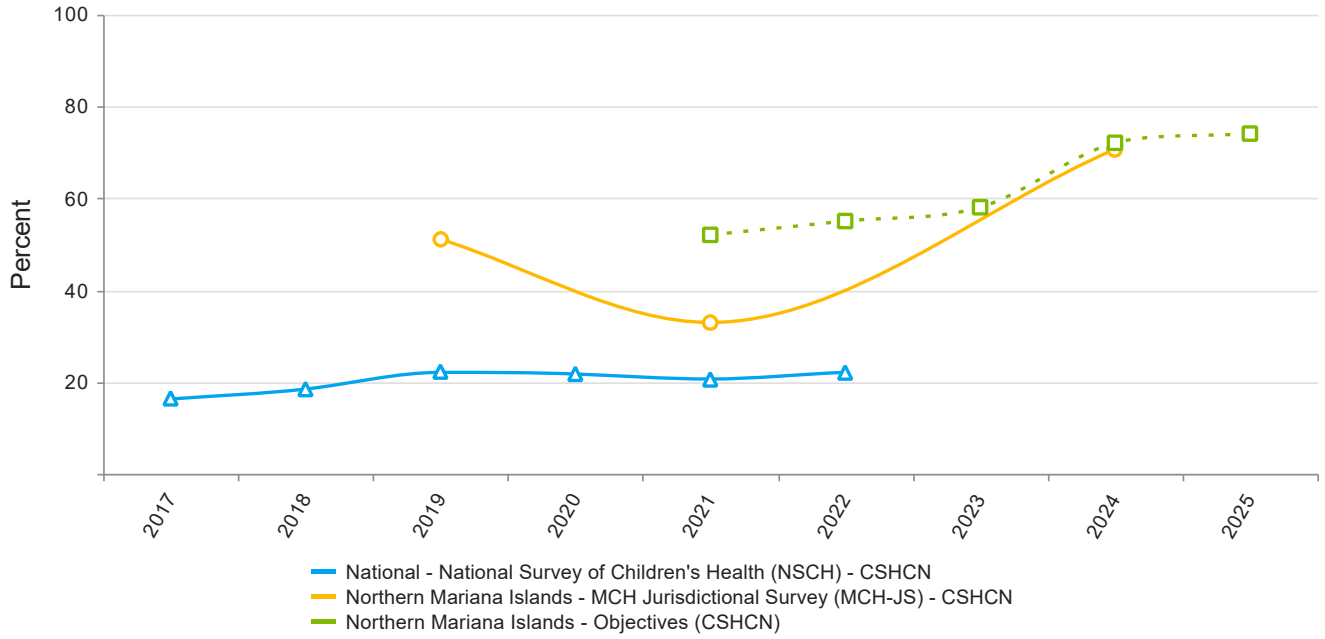
ESM MH.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			10	20	30
Annual Indicator			81	81	52.3
Numerator			51	51	45
Denominator			63	63	86
Data Source			F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	55.0	60.0

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR Indicators and Annual Objectives



NPM TR - Children with Special Health Care Needs

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			52	55	58
Annual Indicator	51.0	51.0	32.8	32.8	70.7
Numerator	183	183	167	167	322
Denominator	358	358	511	511	455
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021	2024

Annual Objectives		
	2024	**2025**
Annual Objective	72.0	74.0

Evidence-Based or –Informed Strategy Measures

ESM TR.1 - Percentage of high school students served by SPED who received information on transition

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10	15	20
Annual Indicator			0	4.9	34.4
Numerator			0	16	115
Denominator			322	329	334
Data Source			Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	35.0	37.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful.	
NPM	
NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	
Five-Year Objectives	
By 2025, increase the percentage of CSHCN who report having a medical home to 25%, an increase from a baseline percentage of 13%.	
Strategies	
Conduct outreach and provide peer support to families of children and youth with special healthcare needs.	
Strengthen partnerships with the CNMI Disability Network Partners (DNP) to establish referral mechanisms to connect CSHCN to medical homes	
ESMs	**Status**
ESM MH.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.	Active
NOMs	
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC	
NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX	
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	
NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC	

State Action Plan Table (Northern Mariana Islands) - Children with Special Health Care Needs - Entry 2

Priority Need

Helping parents/caregivers navigate the health care system for coordinated care

NPM

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR

Five-Year Objectives

By 2025, increase the percentage of adolescents ages 12 through 17 years with and without special healthcare needs who receive transition services to 74% and 61%, respectively, an increase from baseline percentages of 51% and 48%, respectively.

Strategies

Provide education, presentations, and support to high school students with special healthcare needs in making transition into adult healthcare.

ESMs	Status
ESM TR.1 - Percentage of high school students served by SPED who received information on transition	Active

NOMs

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

Children with Special Health Care Needs - Annual Report

Based on the MCH Title V Block Grant guidance, the following annual report is based on activities during FY 2023 (October 01, 2022 through September 30, 2023). The CNMI MCH priorities for Children with Special Healthcare Needs (CSHCN) focus on providing support to parents and caregivers in navigating systems and supporting CSHCN and their families with transition into adult care, priority needs 6 and 7 identified through the 2020 CNMI MCH comprehensive needs assessment. Priorities 6 and 7 align with NPM 11- Percent of children with and without special health care needs, ages 0 through 17, who have a medical home and NPM 12- Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.

Data to inform NPM 11 and NPM 12 is gathered from the CNMI MCH Jurisdictional Survey (MCH-JS), which was conducted in 2019, 2021 and 2023. Based on the CNMI MCH-JS, is estimated that 8.1 percent of children in the CNMI have a special healthcare need.

Since the unwinding of the Public Health Emergency, many of the CSHCN services reverted back to normal operations. Screenings and early identification activities remained continuous such as, service coordination for infants enrolled in EI and Shriner's outreach clinics were scheduled. Training for parents/caregivers of CSHCN and professionals were facilitated using hybrid platform. The learning sessions were offered virtually and via face-to-face throughout the reporting year. Support groups for families with children who have been diagnosed with down-syndrome, autism and who are deaf and hard of hearing (DHH) were able to transition from a virtual meeting format back to a face-to-face setting for project year 2022-2023.

Priority: Helping parents/caregivers navigate the health care system for coordinated care

NPM 11A: Percent of children with special health care needs, ages 0 through 17, who have a medical home

Year	2019	2020	2021	2022	2023
Percentage	13.3	13.3	14.1	14.1	12.5
Numerator	141	141	176	176	138
Denominator	1059	1059	1252	1252	1101

According to data from the CNMI MCH-JS, it is estimated that 12.5 percent of children with special healthcare needs in the CNMI report having a medical home. There is a slight decrease by 1.6 percentage points on this indicator in 2023 compared to the prior reporting year, 2022. However, this measure remains consistent from 2019- 2023.

Strategy: Conduct outreach and provide peer support to families of children and youth with special healthcare needs.

The MCH Title V strategy for conducting outreach and peer support to families of CSHCN in the CNMI is led by the Family-to-Family Health Information Center, known in the community as the F2F. The F2F is staffed by a Family Support Specialist and supported by MCH Title V. The F2F also has registered parent leaders who support outreach and peer support activities. Peer support is offered on one-on-one formatting or group based. The F2F supports the coordination of 3 CSHCN support groups for families and caregivers of children diagnosed with autism, down syndrome, and the deaf or hard of hearing (DHH). In FY2023, there were 19 support groups conducted with 14 parents or caregivers actively involved.

Additionally, in FY2023, there were 6 outreach exhibits conducted by the F2F reaching 730 community members. Many of the events where outreach was conducted were coordinated by members of the Disability Network Partners

(DNP). The CYSHCN program is an active member of the DNP, taking part in meetings, planning, and coordination of community-wide activities focused on disabilities and special health needs.

Table: CNMI CSHCN Outreach Activities October 2022 – September 2023

Month	Topic	Trainer/Facilitator	Participants
October 2022	National Disabilities Employment Awareness Month	Disability Network Partners	98
December 2022	Family Fun Day for International Day of Persons with Disabilities	Disability Network Partners	95
March 2023	Developmental Disability Awareness Month	Disability Network Partners	114
April 2023	Autism Awareness Month: Family Fun Day	F2F Autism Support Group/Autism Society	97
June 2023	CNMI Child Matter Month	Evergreen Learning	161
July 2023	Disability Sports Fest	Disability Network Partners	165

Source: Disability Network Partners

The CNMI MCH is utilizing evidence informed/based measure 11.1 - Percentage of families served by the Family-to-Family Health Information Center who reported having a medical home as a measure on progress on strategies towards making impact on the objectives identified for the priority on medical home.

Evidence Based Strategy Measure 11.1 - Percentage of families served by the Family-to-Family Health Information Center who reported having a medical home.

Table: Percentage of CNMI F2F Families reporting a Medical Home, 2021 & 2023

Year	2021	2023
Percentage	81	52
Numerator	51	45
Denominator	63	86

Data Source: CNMI F2F Health Information Center

In FY2023, the CNMI F2F has a total of 174 families enrolled and receiving various types of services, ranging from information and resource updates via email, participating in learning or training events, individualized or group peer support, etc. In 2021, a survey on medical homes among F2F enrolled families was conducted in which 81 percent of respondents reported having a medical home. The survey was conducted again in 2023, where 26 percent of respondents indicated having a medical home.

In addition to outreach and peer support, the F2F offers learning sessions to help families and caregivers of CSHCN build capacity to be able to effectively partner with medical providers and other professionals. From November 2022 thru September 2023, the CNMI F2F HIC conducted five (5) virtual learning sessions attended by 168 parents/caregivers and professionals, figure 3. The CNMI F2F leverages partnerships throughout the health department and external agencies to coordinate virtual and face-to-face learning opportunities.

Table: F2F Learning Sessions offered in FY2023

Month	Topic	Trainer/Facilitator	Participants
November 2022	Centers for Living Independently (CLI)	Susan Satur, Program Director	17
February 2023	Parent Education Services	Maria Olopai, Community Dev Specialist	41
April 2023	Understanding Functional Behavior & Sensory Processing	Jerry Diaz & Gina Aguillar	37
August 2023	CNMI University Center for Excellence in Developmental Disabilities Program	Eileen A. Babauta, Program Director of UCEDD	25
September 2023	Make Every Bite Count	NMC CREES - Ashley Sikayun	48

Data Source: CNMI F2F Health Information Center

Collaboration with other partnering agencies were made to offer professional development and in-service trainings to help other agencies understand the connections between child health and CSHCN serving programs. Improvement in service coordination among programs and healthcare providers has produced a positive effect with family engagement.

Other family engagement activities supported by MCH Title for the CHSHCN population in FY2023 include Food & Nutrition Classes conducted by the Northern Marianas College's Expanded Food and Nutrition Education Program (EFNEP). The 9-session evidenced based nutrition program was attended by 14 parents and held at the F2F center twice a week from 5pm to 7pm. times to have the classes. The classes were conducted at the F2F center, twice a week from 5:00pm to 7:00pm. Parents received a certificate of completion along with utensils and a cookbook after completion.

The other family engagement event completed was the American Sign Language (ASL) class. The class was made possible through a partnership with the CNMI Public School System's Audiologist and Special Education Instructor. Classes were conducted at the F2F center and covered 8 units of ASL signs such as the alphabets, numbers, emotions, basic conversations, colors, food and many more. The classes were held at the F2F center, twice a week for 6 weeks at 5:00pm to 7:00pm. This class was not only joined by Deaf and Hard of Hearing families but also families who have non-verbal children. There was a total of 11 parents that completed the course.

In July of 2023, the CSHCN parent leaders were able to partake in a Mental Health First Aid (MHFA) training. This training opportunity focused more on the adult aspect of mental health. Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues. Upon completion of the course, the participants are certified for 3 years. The parent leaders continue to learn more about mental health in the grant cycle, in fact CNMI F2F HIC parent leaders were invited to be part of a focus group. The objective of the focus group was to discuss the importance of pediatric mental health care in the CNMI and how the families can access the care that a child needs.

The CNMI MCH Title V program continues to focus on building and sustaining effective partnerships with the CHCC

Children's Clinic providers and nurses. Part of this effort includes coordinating in-service presentation or meet and greet events for providers to be able to connect with our community partners, namely the following agencies:

- Special Education Program
- Early Headstart/Headstart Program
- Early Intervention Program

These face-to-face meetings provided opportunities for the providers to obtain information on the policies and procedures of the various programs in the CNMI that serve CSHCN.

To further build on the partnership between agencies and providers, the MICAH-CSHCN Program organized a meeting between the CNMI PSS-Early Intervention (EI) Program and Dr. Courtney Vargo, OTD, OTR/L, CHT, who is CHCC's Occupational Therapist. The meeting provided an opportunity to discuss strategies for leveraging resources to effectively coordinate services for CSHCN, especially for those who were currently receiving online OT services.

CHCC pediatric clinical staff have been instrumental in ensuring that children receive developmental and other health screenings, diagnostic services, and referrals to the CSHCN program for evaluation into Early Intervention, peer support, transportation vouchers, and other assistance that may be needed. In addition to conducting health screenings at the Children's Clinic, the CHWs under the MICAH Program were able to expand the child find activities to Rota and Tinian together with the Early Intervention team. Activities that were conducted during their visits were ASQ-3 developmental and follow-up hearing screenings at the health centers, conducting outreach via house-to-house visits and participating at the parent cafes. The children that were identified through the screenings were referred to the appropriate programs for services.

Priority: Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful

NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Year	2019	2020	2021	2022	2023
Percentage	13.3	13.3	14.1	14.1	12.5
Numerator	183	183	167	167	322
Denominator	358	511	511	455	455

Data Source: MCH-JS

Data to inform NMP 12 on transition services for CSHCN is obtained through the MCH-JS that has been conducted in the CNMI every two years since 2019. In 2019, it was estimated that 13.3 percent of CSHCN received services necessary to make transition to adult health care. In 2021, this indicator increased slightly and then decreased to 12.5 percent in 2023.

Strategy: Provide education, presentations, and support to high school students with special healthcare needs in making transition into adult healthcare.

Plans to conduct outreach and presentations in FY2023 at local high schools were still impacted due to the COVID-19 Public Health Emergency (PHE). Schools were just starting to shift from virtual learning to face-to-face learning which made it a challenge to finalize scheduling for presentations and educations sessions to occur.

As an alternative, the MICAH Programs collaborated with the Northern Marianas College, University Center for

Excellence in Developmental Disabilities (NMC UCEDD) to plan and conduct a symposium focused on transition. The symposia took place in all 3 islands Saipan, Tinian & Rota. The event brought together all the programs and professionals serving CYSHCN and their families. The purpose was to build capacity on health, education and employment for individuals with disabilities. The event aimed to provide support and promote advocacy through the course of transitioning starting from infancy through adulthood for any individuals identified as a CYSHCN. The event was attended by 225 individuals, including presenters, families of CYSHCN and young adults who had special healthcare needs.

Evidence Based Strategy Measure 12.1 - Percentage of high school students served by SPED who received information on transition

Year	2021	2022	2023
Percentage	0	4.9	34.4
Numerator	0	16	115
Denominator	322	329	334

Data Source: CNMI PSS Special Education Program

The CNMI MCH Title V utilizes ESM 12.1, percentage of high school students served by SPED who receive information on transition as an indicator for assessing progress on strategies implemented to improve access to transition services. In 2022, the CSHCN needs program was able to reach 4.9 percent of high school students enrolled in SPED to provide information on transition. In 2023, 34.4 percent of high school student enrolled in SPED received information on transition.

Other CSHCN Activities

MCH Title V funds are used to support developmental screening activities in the CNMI as part of efforts to identify CSHCN. In 2023, a total of 1,122 developmental screenings were conducted at the Children's Clinic during well-child visits. Children who are identified with developmental risk and who need further assessment are referred to the Early Intervention Program or to the Special Education Program. In 2023, 473 (42.1%) children were identified as requiring additional monitoring or referral to Early Intervention services.

Table: Number of children screened with ASQ and identified as needing monitoring or below developmental cut-off, 2021 – 2022.

Year	Total Number Screened	Number Identified for monitoring or at below cut-off
2021	1,031	372
2022	1,094	216
2023	1,122	473

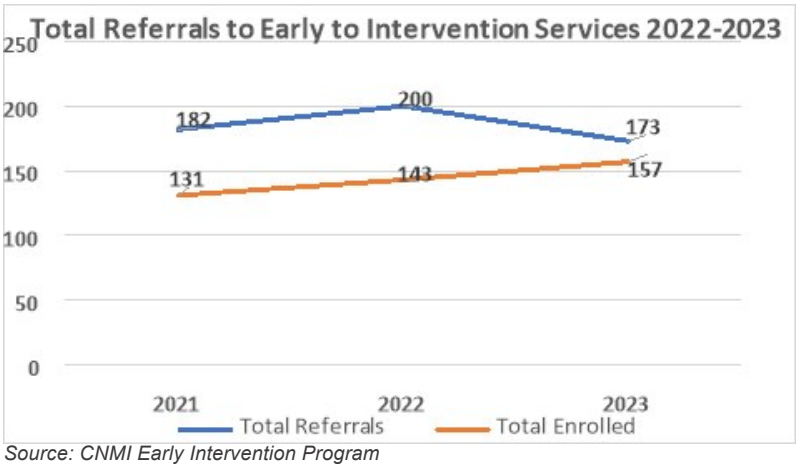
Source: MICAH Program

Early Intervention referral data reports an increase in both the number of referrals to EI and the number of families served compared to the previous year. During the beginning of the school year of 2023, EI Program transitioned to providing services face-to-face full time.

A total of 157 families were served through the Early Intervention Program during the school year 2022-2023. Of those families, 57 children were eligible due to established condition and 100 were identified to have developmental delay. Additionally, 78 infants and toddlers exited the program due to reasons such transitioning to Early Childhood (Part B), families relocating to the US mainland or exiting the program due to meeting milestones or goals. In 2023,

68 % of infants and toddlers referred to EI were from CHCC. Referrals to EI also came from private clinics, daycare, Early Headstart/Headstart Program and parents.

Graph: Total Referrals to CNMI Early Intervention Services, 2021- 2023



Source: CNMI Early Intervention Program

Newborn screenings are critical for detecting potentially fatal or disabling conditions in newborns as early as possible. The CNMI MCH Title V supports newborn hearing screening and newborn metabolic (bloodspot) screening to be able to effectively identify children who may need follow-up care or intervention to reduce or eliminate the effects of the condition. All babies born at the CNMI CHCC receive newborn screenings prior to discharge after birth. Newborn hearing is conducted by the nursery nurses and newborn bloodspot samples are collected and send to the Oregon Department of Public Health laboratory for analysis.

The CHCC-Early Hearing Detection & Intervention (EHDI) Program continues to meet the Joint Committee on Infant Heating (JCIH) national benchmarks. As in the previous year, 2023 data illustrates that 99% of babies born in the CNMI received a newborn hearing screening before one (1) month of age. Of the babies that were screened five (5) infants did not receive a timely newborn screening. Three (3) of the babies were deceased shortly after birth, there was one (1) infant that was immediately sent off-island due to critical condition and one (1) infant was born at home. Out of the 162 babies that needed to come back before 3 months of age, only three (3) babies were lost to follow-up (LTFU). One (1) of the infants passed away, one (1) infant relocated out of the country and did not return for outpatient hearing screening prior to leaving the island and one (1) infant did not return for the appointment. The program continues track and monitor newborn screenings to reduce the risk of LTFU.

Of the two (2) infants that were referred to diagnostic audiological evaluation, two (2) infants were diagnosed with hearing loss, figure 4. Both identified infants were referred to and enrolled with Early Intervention. To further build on capacity with the CNMI EHDI Program, the program collaborated with Dr. Angie Mister, PSS Audiologist to facilitate training on hearing screening using the Otoacoustic Emission Machine (OAE). Dr. Mister successfully trained four (4) CHOWs. All four (4) CHOWs are able to provide updated hearing screenings.

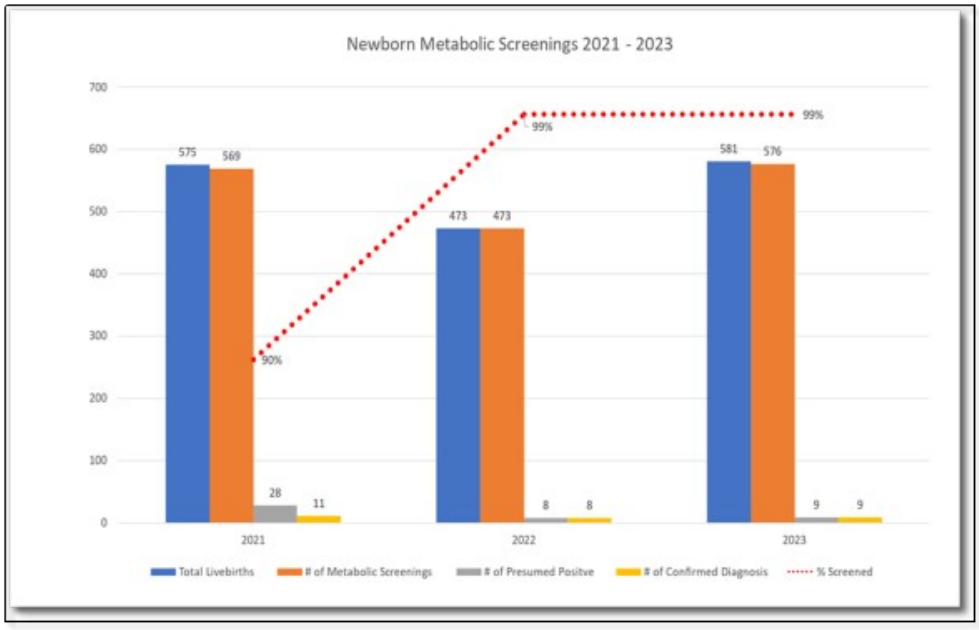
Table : CNMI Newborn Hearing Screening, 2021- 2023

	2021	2022	2023
Births	575	473	581
Screened	569	472	576
Inpatient Pass	469	336	414
Inpatient Refer	100	133	162
Outpatient Pass	90	130	157
Outpatient LTFU	5	3	3
Outpatient Refer to DAE	5	3	2
DAE Pass	4	0	0
DAE Hearing Loss	1	2	2
EI Referral	1	2	2

Source: CNMI EHDI-IS

The MICAH unit works closely with the pediatrics and CHCC laboratory to ensure that newborn bloodspot services remain uninterrupted, identifying children who are identified as needing a secondary screening or diagnostic testing, and assist in contacting families to prevent lost to follow up, figure 8.

Graph. CNMI Newborn Bloodspot Screening, 2022-2023



Source: CHCC Carevue & CNMI EHDI-IS

Of the 581 live births in 2023, 99% completed a newborn bloodspot screening. This has been the trend in the last two (2) years. When an NBS sample is detected to have an abnormal value, Oregon Public Health Laboratory alerts the Children's Clinic Providers and Program Coordinator to inform them to either have the infant get a second screen or for confirmatory testing. All of the nine (9) infants that were presumed positive received confirmed diagnoses and are being followed-up by a primary care provider. MCH Title V funds are used to support shipping costs for the freight services for newborn bloodspot kits. Samples are required to be sent via expedited courier (FedEx) to Oregon Department of Health laboratory to ensure viability of samples.

The Shriner's Hospital Honolulu was able to continue their outreach services in the CNMI in February 2023, figure 9,

serving 132 CNMI children and providing orthotics services to 26. During this outreach both follow-up visits and orthotics continued to provide services at no charge to the families. In addition to the outreach clinics, Shriners continued to provide telehealth services. Additionally, discussions are currently being had for Shriner's to provide expanded orthopedic services locally. These discussions are currently on-going between Public Health, CHCC Hospital and Shriners. Shriners regularly conduct outreach services to the CNMI twice a year, however, the partnership is working to increase this to three (3) times a year.

Table. Shiners Outreach Clinic

Outreach Date:	Total Patients Served:	
February 2023	132	106 established patients / 26 new referrals
	26	Received orthotics services and hardware

Children with Special Health Care Needs - Application Year

The MICAH programs will continue to focus its efforts on improving early identification and screening programs for identifying and connecting children with special healthcare needs with early intervention services and other needed health services. Early intervention improves and enhances the development of a child with developmental delays, special needs, or other concerns. For MICAH Programs, early identification includes newborn screening programs, developmental screening programs, and increasing awareness on developmental milestones, delays, and other special health needs within the community. Early identification will ensure families are connected to resources and supports that empower them in taking an active role in their children's overall care.

According to the 2023 Jurisdictional MCH Survey conducted, 13 percent of children with special health care needs, ages 0 through 17, reported having a medical home in the CNMI. There was no change in this measure when comparing data collected in 2019. The program has made efforts for improving collaboration with medical providers, early intervention services team, and other partnering agencies by providing professional development and in-service trainings to help understand and provide coordinated services to the CSHCN population. However, there were significant changes for the CNMI in FY2024 resulting from the unwinding of the Public Health Emergency (PHE) that impacted the activities that were intended for the year and therefore some were carried into FY2025.

Priorities specific to the needs of children and youth with special health care needs will address all children in the way that CHCC MICAH Programs strives; comprehensively and inclusively. One of the main goals of the Special Health Care Needs program is to provide care coordination, so that children and their families can navigate systems to gain optimal health in a consistent and comprehensive way. During the 2020 needs assessment process, it became apparent that family support was emerging as a high need and that those supports include understanding available resources. Understanding the resources and how to navigate them can reduce caregiver stress. This priority exemplifies the collaboration and partnership building principles that CHCC MICAH programs promote and is willing to sustain so that all children with health care needs receive the care they need. Currently, the CSHCN section has 4 Community Health Outreach Workers serving CSHCN families from 2 to 4 and a full time Family Support Specialist focused on family engagement and building capacity with parents and families of CSHCNs to be able to effectively partner with medical providers and advocate for their needs.

Priority needs 6 for the CSHCN domain is helping parents/caregiver navigate the healthcare system. This priority is aligned with national performance measure 11, percent of CSHCN ages 0 through 17 years who have a medical home. The program aims to increase the percentage of CSHCN who report having a medical home to 25% by 2025 by conducting outreach and providing peer support for families of children with special health needs.

Priority Need 6: Helping parents/caregivers navigate the healthcare system

NPM 11: Percent of CSHCN ages 0 through 17 years who have a medical home.

Objective: By 2025, increase the percentage of CSHCN who report having a medical home to 25%, an increase from the baseline of 13.3%.

Strategy: Strengthen partnerships with the CNMI Disability Network Partners (DNP) to establish referral mechanisms to connect CSHCN to medical homes.

The CSHCN Program of the CNMI MICAH unit will continue to support screenings and early identification activities to identify children with special healthcare needs and ensure that they are connected to services and a medical home. This effort will be done in collaboration with partners such as the hospital nursery, NICU, children's clinic, Early Intervention program, and the various MICAH programs that also serve children and families.

Outreach and peer support will be provided by community health workers and the Family Support Specialist, who are part of the CSHCN program team. Monthly learning sessions and other capacity building activities will be made available for parents of CSHCN to attend to improve access to information and to improve partnerships between parents and medical providers and other CSHCN serving professionals including organizations that are a part of the Disability Network Partners (DNP).

For FY 2025, October 2024 through September 2025, the following activities provide an outline of the strategy that will be implemented for improving the percentage of CSHCN who report having a medical home:

Outreach and Peer Support

- Conduct Outreach & In-Service presentations to Parent Teacher Student Association (PTSA), school teachers/staff and high-school clubs.
- Strengthen partnership with DNP members by providing updates on the number of families accessing peer supports, training and other events that help connect children to medical homes.
- Conduct evaluation or feedback survey on presentations and peer support services.
- Conduct outreach in Rota and Tinian to enroll potential parent leaders for F2F HIC as part of efforts to connect families and children on those islands to medical homes.

Evidence Based Strategy Measure (ESM) 11.1: Number of children served by the Family-to-Family Health Information Center who reported having a medical home.

To measure the impact of the strategy on the priority area and objective, the MCH program will gather data on this measure through a survey of families who have accessed the Family-to-Family Health Information Center or those who attended presentations provided by the program who report having a medical home.

Priority Need 7: Support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful.

NPM 12: Transition- Percent of adolescents with and without special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care.

Objective: By 2025, increase the number of adolescents ages 12 through 17 years with and without special healthcare needs who receive transition services to 74% and 61%, respectively, an increase from the baseline of 51% and 48%.

Strategy: Provide education, presentations, and support to high school students with special healthcare needs and/or their parents in making transition into adult healthcare.

Priority need 7 is support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful. This priority is linked to NPM 12, percent of adolescents with special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care.

For FY 2025, October 2024 through September 2025, the following activities provide an outline of the strategy

identified to address priority need 7: providing education, presentations, and support for high school students and their families with special healthcare in making transition into adult healthcare:

Transition Presentations and Services

- Meet with CNMI PSS Special Education Program to discuss strategies and activities to incorporate information on healthcare transition during SPED IEP reviews.
    - Draft and create Healthcare Transitions informational sheets (utilizing Got Transition)
    - Draft and create consent forms to be presented to CSHCN families during IEP transition meetings
    - Meet with Parent-Teacher-Student Association (PTSA) to schedule presentations on healthcare transitions for the school year.
- Leverage partnerships with the PSS Youth Advisory Panel (YAP) to build capacity among youth school leaders to facilitate presentation to youth peers on healthcare transition.
- Review CNMI F2F Roadmap for CYSHCN families with parents, providers and partner agencies.
- Partner with the CNMI Disability Network Partners (DNP) to highlight healthcare transition during annual transition conferences.
- Continue to collaborate with the F2F to provide virtual learning/face-to-face sessions on transition to families.
- Conduct surveys to acquire information regarding medical home and healthcare transition services.
- Assess the current transition protocol for teens seen at the CHCC Children's Clinic and partner with the CHCC pediatrics leaderships on strategies for improvement, if needed, utilizing assessment resources from Got Transition and Patch Program.

Cross-Cutting/Systems Building

State Performance Measures

SPM 2 - Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10	15	20
Annual Indicator			2.1	34	49.2
Numerator			2	32	61
Denominator			94	94	124
Data Source			CHCC HUMAN RESOURCES	CHCC HUMAN RESOURCES	CHCC Training Spreadsheet
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	50.0	55.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Professionals have the knowledge and skills to address the needs of maternal and child health populations

SPM

SPM 2 - Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.

Five-Year Objectives

By 2025, increase the number of CHCC Public Health staff (PHS) who complete training on MCH priorities and topics by 25% from baseline.

Strategies

Implement a learning management system to provide training and capture completion rates

Cross-Cutting/Systems Building - Annual Report

A key finding in the 2020 CNMI MCHB 5 - year needs assessment suggested a need for professionals who work with the MCH populations to have the knowledge and skills necessary to address their needs. To improve the delivery of quality health and public health services, and enhance skills, abilities, and performances of MCH serving professionals, it is critical to provide capacity building and training opportunities to ensure a competent workforce, but also support retention, morale and productivity.

To address this need, a State Cross-cutting/system building Priority Need 8, and State Performance measure 2 (SPM-2) was established.

Priority Need 8: **Professionals have the knowledge and skills to address the needs of maternal and child health populations**

State Performance Measure 2- Percentage of CHCC staff and other professionals who serve MCH populations that receive training on MCH priorities and/or related strategies was developed to be able to report on progress and impact of the strategies implemented to address priority need 8.

After a careful review of SPM-2, an update to the original version was initiated to reflect a realistic approach for addressing Priority Need 8. The updated version of SPM – 2 reads as follows:

State Performance Measure 2- Percentage of CHCC Public Health staff who receive training on MCH priorities and/or related topics.

Strategy: Provide training to public health professionals on MCH priorities and/or strategies that support improvements in national outcome and performance measures.

The CNMI MCH Title V strategy for addressing priority need 8 on public health staff capacity around MCH topics was to provide or make training on MCH related topics accessible to public health staff. One of the initial challenges with being able to track progress in this measure was the lack of a central location for professional development data to be reported and gathered. The Division encountered difficulties in trying to report accurate numbers of training, types of training, and the number of staff taking part in capacity building opportunities made possible by the MCH Title V, the Division of Public Health, the CHCC, or through local, regional and national partners.

In FY2023, the CHCC Professional & Organizational Development (POD) Coordinator led the compilation of data for capacity building and training events completed by staff. This laid the foundation for a centralized database for staff within the CHCC, including Public Health, to report on the types of training events that were being completed. The database was developed with Microsoft Excel. However, the MCH Title V Project Director is working closely with the CHCC Health Information Technology Director to procure a learning management system (LMS) for the POD office to be able to improve data capacity to better identify training needs, track completion, and assess the training completion rates.

In FY2023, there were about 130 employees under the Division of Public Health Services. Staff members took part in online trainings, locally based trainings, as well as conferences and other convening off-island within the pacific region or the US mainland. There were 132 participants in trainings offered to Public Health staff that focused on topics related to the various MCH population domains, see table below. There were 6 training participants from the

Communicable Disease programs section on topics related to adolescent health, 74 from the MICAH programs staff on various health domains topics, and 52 from Non-Communicable Disease Programs staff related to adolescent, child, women's health and general MCH. No staff from the Environmental Health & Disease Prevention unit reported completing any trainings related to MCH population domains in FY2023.

Table. Training participants by MCH population and Public Health Unit, FY2023.

Training by MCH Population	Communicable Disease Programs	Environmental Health & Disease Prevention	Maternal, Infant, Child & Adolescent Health Programs	Non-Communicable Disease Programs	Total
Adolescent Health	6		2	5	13
Child Health			27	21	48
CSHCN			16		16
Infant Health			2		2
General MCH			21	3	24
Women's Health			6	23	29
Total	6	0	74	52	132

Source: CHCC POD Training Database

Cross-Cutting/Systems Building - Application Year

Investing in workforce development and capacity building around MCH related topics were identified as priorities during the 2020 comprehensive MCH 5-year needs assessment. State Performance Measure - 2 (SPM-2) addresses Priority Need 8 in which the objective is to provide training to at least 25% of the staff of the Division of Public Health on MCH topics.

Priority Need 8: Professionals have the knowledge and skills to address the needs of maternal and child health populations

State Performance Measure 2- Percentage of CHCC Public Health Services (PHS) staff who complete training on MCH priorities and related topics.

Objectives: **By 2025, increase the number of CHCC Public Health staff (PHS) who complete training on MCH priorities and topics by 25% from baseline.**

Strategy: Provide training to CHCC Public Health staff on MCH priorities and other related topics.

Training activities in FY2022 and FY2023 were impacted by the COVID-19 pandemic and activities that were postponed will continue into FY2024. In FY2023, the MICAH programs were able to identify the following MCH training topics priorities to be conducted in FY2024. These training topics will continue to be a focus in FY2025.

Topic	Priority area linkage	NPM/SPM Linkage
Recommended screenings for Women ages 18-44 years	Priority 1- Women's preventive care and screenings	NPM 1- Percent of women of reproductive age with preventive visit
Breastfeeding Bootcamp	Priority 2- Breastfeeding	NPM 4- Percent of infants breastfed
Got Transition	Priority 5- Transition	NPM 12
Motivational Interviewing	Priority 1-7	NPM 1,4,8,10,11,12
Adolescent Behavioral Screenings and Referrals to care	Priority 4- behavioral health interventions for teens	NPM 10,11
Project/Program Evaluation	Priorities 1-8	NPM 1,4,8,10,11,12
Data Analysis & Visualization	Priorities 1-8	NPM 1,4,8,10,11,12
Nutrition through the Life Course	Priorities 2, 4	NPM 4, 8
Basic Quality Improvement	Priorities 1-8	NPM 1,4,8,10,11,12

In FY2024, the CHCC Health Information Technology department in partnership with Public Health Services was able to identify funding and begin the procure process for a learning management system. This system will build the MICAH programs management and staff capacity to be able to offer training related to MCH priorities. Additionally,

the system will enable better data reporting and allow management to evaluate staff training so that training plans are better aligned to address workforce needs.

III.F. Public Input

The CHCC MICAH Programs continue to provide an open and collaborative approach with various agencies, families, and other stakeholders to facilitate public input. The public input process involves several efforts including public web postings on social media sites, outreach through email to stakeholders/partners, and participation in advisory committees, workgroups, and partnership meetings.

Each year, MICAH Programs staff members participate in annual community events such as the Annual Red Cross Walk-a-Thon and Safe Jamboree. Since these events are attended by hundreds of community members, programs participate to ensure the community is aware of the program's priorities, services, and goals. Additionally, the MCH Program coordinates the Annual CNMI Women's Health Month in May, where the program uses the opportunity to communicate to partner agencies, community members, and other stakeholders regarding the CNMI MCH program's priorities, activities, and strategies for improving health outcomes.

The CHCC MICAH Program Coordinators continue to participate in regular meetings with providers who serve MCH populations, including Pediatricians, OB/GYNs, Family Practice and Internal Medicine Physicians, as well as other clinical staff for sharing updates on health indicators and activities that support priority action items throughout the year. Feedback and input are received from clinical partners during these meetings. Meetings with partner programs, both internal to CHCC and external, are held frequently throughout the year where input and feedback is also received. The information provided through these meetings are a critical component in the identification and selection of priority areas and strategies to impact the measures selected.

Considering that the annual report/application is a lengthy document at almost 300 pages, an executive summary is made available during the annual report and application development process on the CHCC website along with the contact information for the MCH Title V Project Director inviting for public input or comments.

The executive summary is also shared electronically on social media and via email, with internal and external partners and key stakeholders during the annual report and application development process. The draft report in its entirety made available to partners and stakeholders to review.

The CNMI MCH Title V Application Annual report is made available online on the CHCC website and comments are accepted year-round.

III.G. Technical Assistance

The CNMI relies primarily on national technical assistance to develop leadership and build public health capacity within the health department and in MCH population serving agencies. Our efforts to explore opportunities were largely delayed in 2021 due to the COVID-19 pandemic.

In 2023, the CNMI continued to utilize technical assistance available through the HRSA Maternal and Child Health Bureau (MCHB) and the Association of Maternal and Child Health Programs (AMCHP). Training and presentation events were attended virtually and included Title V Learning Labs, consultation with project officers and AMCHP regional representatives, the AMCHP national conference, and recurring region IX calls.

In 2023, the CHCC Division of Public Health Services established an Employee Relations and Engagement Committee focused on identifying employee recruitment, retention, and capacity building needs, in relation to the core competencies for public health professionals. This committee completed an assessment on employee engagement and staff capacity building and development needs in 2023 and results being in analyzed in 2024 as part of workforce development planning and the Division strategic planning.

The CNMI MICAH Programs has received technical assistance and continues to engage with the following national and regional partners for supporting MCH efforts:

- Association of Maternal and Child Health Programs (AMCHP)
- Reproductive National Health Training Center (RHNTC)
- Association of State and Territorial Health Officials (ASTHO)
- Pacific Islands Health Officers Association (PIHOA)
- Public Health Accreditation Board (PHAB)
- National Network of Public Health Institutes (NNPHI)

For FY2025, the CNMI MCH Title V team seeks to request technical assistance from the following HRSA MCHB capacity building investments for improving staff capacity and program implementation and improvement efforts:

Technical Assistance Center	Linkage to CNMI activities
Got Transition / Center for Health Care Transition Improvement	National Performance Measure 12: Transition- Percent of adolescents with and without special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care.
MCH Nutrition Training Program	Priority Need 4: Obesity related issues including nutrition and physical activity

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MP_MOU_FY24.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MICAH Org Chart 2024.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Northern Mariana Islands

	FY 25 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 490,000	
A. Preventive and Primary Care for Children	$ 149,378	(30.4%)
B. Children with Special Health Care Needs	$ 149,140	(30.4%)
C. Title V Administrative Costs	$ 43,818	(9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 342,336	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 417,385	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 417,385	
A. Your State's FY 1989 Maintenance of Effort Amount $ 395,500		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 907,385	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 8,599,630	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 9,507,015	

OTHER FEDERAL FUNDS	FY 25 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 96,750
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,123,516
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 175,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 200,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 6,669,364

	FY 23 Annual Report Budgeted		FY 23 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 466,540 (FY 23 Federal Award: $ 490,258)		$ 489,239	
A. Preventive and Primary Care for Children	$ 144,274	(30.9%)	$ 154,547	(31.5%)
B. Children with Special Health Care Needs	$ 149,519	(32%)	$ 153,783	(31.4%)
C. Title V Administrative Costs	$ 42,004	(9%)	$ 42,005	(8.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 335,797		$ 350,335	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 0		$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 479,204		$ 463,932	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 479,204		$ 463,932	
A. Your State's FY 1989 Maintenance of Effort Amount $ 395,500				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 945,744		$ 953,171	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 7,930,007		$ 8,902,682	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 8,875,751		$ 9,855,853	

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020	$ 190,049
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 2,793,609	$ 3,222,904
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 93,175	$ 75,627
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 225,227	$ 92,361
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 935,344	$ 856,594
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 83,898
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 201,534
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 200,000	$ 196,687
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 3,187,632	$ 3,983,028

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Other Funds consist of salaries of CHCC providers providing direct care to the CNMI MCH population and other clinic support staff.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Majority of the Preventive and Primary Care for Children funds were utilized to support MCH staff that mostly provides enabling services. In addition, some funds were utilize to support staff conducting Public Health Services and Systems. Funds were expended mostly to support enabling services such as supplies, public education and awareness and printing services.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Majority of the Children with Special Health Care Needs funds were utilized to support MCH staff that mostly provides enabling services. In addition, some funds were utilize to support staff conducting Public Health Services and Systems. Funds were expended mostly to support enabling services such as supplies and freight and handling.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Other Funds consist of salaries of CHCC providers providing direct care to the CNMI MCH population and other clinic support staff.	

Data Alerts: None

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

State: Northern Mariana Islands

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 62,280	$ 57,177
2. Infants < 1 year	$ 62,281	$ 57,178
3. Children 1 through 21 Years	$ 149,378	$ 154,547
4. CSHCN	$ 149,140	$ 153,783
5. All Others	$ 23,103	$ 24,549
Federal Total of Individuals Served	$ 446,182	$ 447,234

IB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 66,795	$ 88,899
2. Infants < 1 year	$ 66,794	$ 88,900
3. Children 1 through 21 Years	$ 154,802	$ 135,384
4. CSHCN	$ 128,994	$ 150,750
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 417,385	$ 463,933
Federal State MCH Block Grant Partnership Total	$ 863,567	$ 911,167

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Northern Mariana Islands

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 242,759	$ 267,586
3. Public Health Services and Systems	$ 247,241	$ 221,653
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 490,000	$ 489,239

IIB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 396,535	$ 422,019
3. Public Health Services and Systems	$ 20,850	$ 41,914
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 417,385	$ 463,933

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Northern Mariana Islands

Total Births by Occurrence: 581 **Data Source Year: 2023**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	576 (99.1%)	9	9	9 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	Hearing Loss
Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease
Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Mucopolysaccharidosis Type II (MPS II)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy			

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing Screening	576 (99.1%)	2	2	2 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The MCH and CSHCN Program have implemented and Inter-Agency Agreement between the CNMI Public School System (PSS) Part C of the DIEA and the Commonwealth Healthcare Corporation to provide services to infants and toddlers (birth to three years) who have been identified as having a disability and who would then be enrolled into the Early Intervention Services (EIS) Program.

While enrolled in EIS, services such as speech therapy, special instruction, physical therapy, vision, hearing, and psychological services are rendered and provided to families at no cost. Children identified as having a disability at birth and have surpassed the age of three years are transitioned into the Early Childhood Program that provides services to children ages three years to five years old. Children above the age of five years are transitioned into the Special Education Program under PSS where they will continue to receive on going service coordination.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2023**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: The data represents the total number of live births in the CNMI as reported by the CNMI Health & Vital Statistics Office (HVSO).	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2023**
	Column Name:	**Core RUSP Conditions**
	Field Note: 576 received newborn hearing and metabolic/bloodspot screenings.	

Data Alerts: None

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

State: Northern Mariana Islands

Annual Report Year 2023

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

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	573	65.0	0.0	10.0	25.0	0.0
2. Infants < 1 Year of Age	581	66.0	0.0	10.0	24.0	0.0
3. Children 1 through 21 Years of Age	6,015	64.0	0.0	17.0	16.0	3.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,135	0.0	0.0	0.0	0.0	100.0
4. Others	2,274	43.0	0.0	39.0	17.0	1.0
Total	9,443					

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	467	No	573	100.0	573	573
2. Infants < 1 Year of Age	468	No	581	100.0	581	581
3. Children 1 through 21 Years of Age	17,922	No	17,536	50.5	8,856	6,015
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,384	No	1,135	100.0	1,135	1,135
4. Others	32,770	Yes	32,770	48.6	15,926	2,274

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2023**
	Field Note: Number of Pregnant women with live births in year 2023	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2023**
	Field Note: Number of live births year 2023	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: Number of children 1 through 21 years who visited CHCC	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: Number of Children enrolled in Special Education and Early Intervention Programs	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2023**
	Field Note: Number of females > 20 years who visited Family Care Clinic, Family Planning Mobile Clinic and Women's Clinic	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2023**
	Field Note: The CNMI Title V MCH Program supports direct, enabling, and public health services and systems and estimates areach of all pregnant women. Case management for high risk prenatal patients are provided by MCH funded personnel and trainings and other capacity building needs of the nursing staff at the Labor & Delivery and Obstetrics departments. The CNMI has a single birthing facility and no home births are recorded for the reporting year. Additionally, communications and other messaging campaigns on topics such as early prenatal care, vaccinations, as well as patient handout and educational materials are provided through a variety of mechanisms (i.e Social Media, Radio, posters, flyers, brochures, etc).	

2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2023**
	Field Note: Number of Pregnant women with live births at CHCC in 2023	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2023**
	Field Note: Denominator represents the total number of live births at CHCC during year 2022 (Data Source - Health and Vital Statistics). The CNMI MCH Title V supports direct, enabling, and public health services and systems which is estimated to reach all infants less than 1 years old in the CNMI. The CNMI MCH Title V supports training for nurses, child care providers, home visitors, and other public health program staff who serve infants or their families. Additionally, communications materials on infant health topics such as breastfeeding, developmental screening and milestones, and vaccinations are disseminated through patients/family handout or educational materials, and advertisements on radio, social media, newspaper or during exhibits at community events.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2023**
	Field Note: Number of live births at CHCC in 2023	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**
	Field Note: Number of children ages 1 through 21 years of age seen at CHCC during 2022 (Data Source: CareVue EHR). The CNMI MCH Title V supports direct, enabling, and public health services and systems for children ages 1 through 21 years by providing training and capacity building for hospital and clinic nurses and providers, public health staff, public school system staff members, and parents. Additionally, community awareness and educational information on topics relating to child health are also supported by Title V and disseminated through a variety of mechanisms, including social media, radio ads, newspaper, and others.	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2023**
	Field Note: Number of children ages 1 through 21 Years of age according to the 2023 U.S. International Data Base	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**

	Field Note: The CNMI MCH Title V supports direct, enabling, and public health services and systems for children with special healthcare needs by providing case management and service navigation for infants and children up to 3 years, training for parents and service providers of children with special healthcare needs, assistance with transportation to healthcare and related appointments, and community awareness and health promotion activities. Additionally, MCH Title V supports screening and early identification activities.	
8.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Denominator**
	Fiscal Year:	**2023**
	Field Note: Number of children served by SPED and EI in 2022 to 2023 school year.	
9.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2023**
	Field Note: Others represent Females ages 22 years and older who received health care services at CHCC during 2022. Data Source: CareVue EHR The CNMI MCH Title V supports direct, enabling, and public health services and systems for other populations including family planning services for women and men of reproductive age, educational outreach during community events to promote primary and preventive health services, support for primary care and preventive services through the CHCC mobile clinic, and community awareness activities via social media, radio and newspapers.	

Data Alerts:

1.	Pregnant Women Denominator is greater than or equal to 110% of the Pregnant Women Reference Data. Please double check and justify with a field note.
2.	Infants Less Than One Year Denominator is greater than or equal to 110 % of the Infants Less Than One Year Reference Data.Please double check and justify with a field note.
3.	Children with Special Health Care Needs 0 through 21 Years of Age Denominator is less than or equal to 90% of the Children with Special Health Care Needs 0 through 21 Years of Age Reference Data. Please double check and justify with a field note.
4.	Pregnant Women, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
5.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
6.	Children with Special Health Care Needs 0 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

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

State: Northern Mariana Islands

Annual Report Year 2023

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	573	5	0	0	0	213	276	78	1
Title V Served	573	5	0	0	0	213	276	78	1
Eligible for Title XIX	375	2	0	0	0	86	225	62	0
2. Total Infants in State	581	6	0	0	0	213	283	78	1
Title V Served	581	6	0	0	0	213	283	78	1
Eligible for Title XIX	381	2	0	0	0	86	231	62	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
Title V Program Workforce

State: Northern Mariana Islands

Reporting on Form 7 in the 2025 Application/2023 Annual Report is optional. The state has opted-out of providing Form 7 data. Reporting on Form 7 is mandatory for 2026 Application/2024 Annual Report.

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Northern Mariana Islands

1. Title V Maternal and Child Health (MCH) Director	
Name	Heather Pangelinan
Title	Director
Address 1	1178 Hinemlu St
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 234-8950
Extension	
Email	heather.pangelinan@chcc.health

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Shiella Deray
Title	CSHCN Program Manager
Address 1	1178 Hinemlu St
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 234-8950
Extension	
Email	shiella.deray@chcc.health

3. State Family Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Heather Pangelinan
Title	Director
Address 1	1178 Hinemlu St
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 234-8950
Extension	
Email	heather.pangelinan@chcc.health

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(670) 287-7718

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Northern Mariana Islands

Application Year 2025

No.	Priority Need
1.	Ability to find and see a doctor when needed (access to health services)
2.	Education and support to help with breastfeeding.
3.	Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care
4.	Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity
5.	Coping skills and suicide prevention
6.	Helping parents/caregivers navigate the health care system for coordinated care
7.	Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful.
8.	Professionals have the knowledge and skills to address the needs of maternal and child health populations

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Access to health services- ability to find and see a doctor when needed.	New
2.	Education and support to help with breastfeeding.	Revised
3.	Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care	Revised
4.	Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity	New
5.	Coping skills and suicide prevention	Revised
6.	Helping parents/caregivers navigate the health care system for coordinated care	New
7.	Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful	New
8.	Professionals have the knowledge and skills to address the needs of maternal and child health populations	New

Form 10
National Outcome Measures (NOMs)

State: Northern Mariana Islands

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

Percent of infants who were ever breastfed

NOM - Percent of pregnant women who receive prenatal care beginning in the first trimester (Early Prenatal Care, Formerly NOM 1) - PNC

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	63.7 %	2.2 %	295	463
2021	68.8 %	1.9 %	391	568
2020	56.7 %	2.0 %	356	628
2019	49.9 %	1.9 %	338	677
2018	49.4 %	2.1 %	278	563
2017	52.2 %	2.6 %	188	360
2016	41.9 %	2.4 %	173	413
2015	39.7 %	2.4 %	167	421
2014	53.9 %	2.2 %	269	499
2013	46.4 %	2.1 %	275	593
2012	43.6 %	1.8 %	319	731
2011	60.7 %	4.1 %	88	145
2010	48.3 %	1.9 %	332	687

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2024	88.7 %	7.2 %	486	548
2021	98.3 %	1.7 %	1,972	2,007
2019	77.0 %	10.0 %	1,252	1,627

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	57.8
Numerator	336
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM PNC - Notes:

Percentage of women who received first prenatal care visit during the first trimester (before 13 weeks of gestation).

Data Alerts: None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

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

State Provided Data	
	2023
Annual Indicator	292.6
Numerator	17
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM SMM - Notes:

Percentage of deliveries hospitalization with indications of severe morbidity including Maternal transfusion, Hypertension Eclampsia, Unplanned Hysterectomy, Admission to ICU, Ruptured Uterus, and Unplanned OR procedures.

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2018_2022	NR	NR	NR	NR
2017_2021	NR	NR	NR	NR
2016_2020	NR	NR	NR	NR
2015_2019	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	0.0
Numerator	0
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM MM - Notes:

There were no related deaths due to aggravated pregnancy or incidental causes and occurring within 42 days of the end of pregnancy.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 3. Please review your data to ensure this is correct.

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	10.9 %	1.4 %	51	467
2021	8.1 %	1.1 %	46	570
2020	10.7 %	1.2 %	67	628
2019	7.1 %	1.0 %	48	679
2018	10.9 %	1.3 %	61	561
2017	7.6 %	1.4 %	27	356
2016	7.8 %	1.3 %	32	411
2015	7.8 %	1.3 %	33	424
2014	7.6 %	1.2 %	39	516
2013	7.8 %	1.0 %	53	677
2012	6.4 %	0.8 %	54	847
2011	7.3 %	0.8 %	75	1,032
2010	7.2 %	1.1 %	42	580
2009	8.6 %	0.8 %	95	1,107

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2024	11.9 %	2.3 %	1,616	13,620
2021	13.3 %	2.5 %	2,277	17,149
2019	10.8 %	2.0 %	1,856	17,149

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	10.5
Numerator	61
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM LBW - Notes:

Percentages of low birth deliveries weighing < 2500 grams

Data Alerts: None

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	12.0 %	1.5 %	56	466
2021	9.0 %	1.2 %	51	568
2020	10.7 %	1.2 %	67	628
2019	8.7 %	1.1 %	59	682
2018	10.4 %	1.3 %	59	565
2017	7.8 %	1.4 %	28	359
2016	12.1 %	1.6 %	50	412
2015	9.7 %	1.4 %	41	424
2014	9.3 %	1.3 %	48	517
2013	9.8 %	1.2 %	65	665
2012	7.6 %	0.9 %	62	813
2011	6.8 %	0.8 %	70	1,028
2010	7.6 %	0.8 %	78	1,023
2009	8.2 %	0.8 %	90	1,100

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2024	16.9 %	3.0 %	2,308	13,620
2021	15.5 %	2.2 %	2,666	17,149
2019	14.2 %	3.2 %	2,431	17,149

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	10.5
Numerator	61
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM PTB - Notes:

Percent of Preterm Births before 37 weeks of complete gestation

Data Alerts: None

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	28.3 %	2.1 %	132	466
2021	29.2 %	1.9 %	166	568
2020	28.3 %	1.8 %	178	628
2019	28.0 %	1.7 %	191	682
2018	30.6 %	1.9 %	173	565
2017	33.4 %	2.5 %	120	359
2016	27.2 %	2.2 %	112	412
2015	28.8 %	2.2 %	122	424
2014	28.6 %	2.0 %	148	517
2013	31.1 %	1.8 %	207	665
2012	28.2 %	1.6 %	229	813
2011	28.0 %	1.4 %	288	1,028
2010	22.6 %	1.3 %	231	1,023
2009	28.4 %	1.4 %	312	1,100

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	31.7
Numerator	184
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM ETB - Notes:

Percent of live births born at 37, 38 weeks of complete gestation

Data Alerts: None

NOM - Percent of non-medically indicated early elective deliveries (Early Elective Delivery, Formerly NOM 7) - EED

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

NOM EED - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	14.5 ϟ	4.6 ϟ	10 ϟ	692 ϟ
2018	17.5 ϟ	5.6 ϟ	10 ϟ	573 ϟ
2017	27.3 ϟ	8.8 ϟ	10 ϟ	366 ϟ
2016	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2015	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2014	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2013	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2012	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2011	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2010	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2009	NR ⚑	NR ⚑	NR ⚑	NR ⚑

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	11.9
Numerator	7
Denominator	586
Data Source	HVSO
Data Source Year	2023

NOM PNM - Notes:

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

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	13.8
Numerator	8
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM IM - Notes:

Infant mortality rate per 1,000 live births

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2019				
2018				
2018				
2017				
2016				
2015				
2014				
2013				
2012				
2011				
2010				
2009				

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	6.9
Numerator	4
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM IM-Neonatal - Notes:

Neonatal mortality rate per 1,000 live births

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	6.9
Numerator	4
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM IM-Postneonatal - Notes:

Post neonatal mortality rate per 1,000 live births

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

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

State Provided Data	
	2023
Annual Indicator	344.2
Numerator	2
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM IM-Preterm Related - Notes:

Preterm-related mortality rate per 100,000 live births

Data Alerts: None

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	7.5 %	1.3 %	34	450

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	3.6
Numerator	21
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM DP - Notes:

Percent of women who drink alcohol in the last 3 months of pregnancy

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

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

State Provided Data	
	2023
Annual Indicator	0.0
Numerator	0
Denominator	581
Data Source	HVSO
Data Source Year	2023

NOM NAS - Notes:

No neonatal abstinence syndrome case was identified in 2022 live birth dataset

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 11. Please review your data to ensure this is correct.

NOM - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL) (Newborn Screening Timely Follow-Up, Formerly NOM 12) - NBS

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

NOM NBS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

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

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	25.2 %	3.2 %	3,327	13,204
2021	17.0 %	2.8 %	2,728	16,051
2019	13.0 %	3.0 %	2,138	16,434

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2020	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	30.7
Numerator	2
Denominator	6,513
Data Source	HVSO, US CENSUS IDB
Data Source Year	2023

NOM CM - Notes:

Child Mortality rate, ages 1 through 9, per 100,000

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	NR	NR	NR	NR
2021	NR	NR	NR	NR
2020	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	10.7
Numerator	1
Denominator	9,357
Data Source	HVSO, US CENSUS IDB
Data Source Year	2023

NOM AM - Notes:

Adolescent mortality rate ages 10 through 19, per 100,000

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020_2022	NR	NR	NR	NR
2019_2021	NR	NR	NR	NR
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
2008_2010	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	0.0
Numerator	0
Denominator	5,057
Data Source	HVSO US Census IDB
Data Source Year	2023

NOM AM-Motor Vehicle - Notes:

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

Data Alerts:

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

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020_2022	NR	NR	NR	NR
2019_2021	NR	NR	NR	NR
2018_2020	NR	NR	NR	NR
2017_2019	NR	NR	NR	NR
2016_2018	NR	NR	NR	NR
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	0.0
Numerator	0
Denominator	5,057
Data Source	HVSO, US Census IDB
Data Source Year	2023

NOM AM-Suicide - Notes:

Adolescent suicide rate, ages 15 through 19, per 100,000

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 16.3. Please review your data to ensure this is correct.

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	8.1 %	1.6 %	1,101	13,620
2021	7.3 %	1.6 %	1,252	17,149
2019	6.2 %	1.4 %	1,059	17,149

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM CSHCN - Notes:

None

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	0 %	0	0	1,101
2021	0 %	0	0	1,252
2019	2.6 %	2.6 %	28	1,059

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder (Autism, Formerly NOM 17.3) - ASD

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	2.0 %	0.7 %	250	12,254
2021	0.2 %	0.2 %	23	14,137
2019	2.4 %	1.0 %	343	14,237

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM ASD - Notes:

None

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	2.6 %	0.8 %	324	12,254
2021	3.5 %	1.5 %	502	14,137
2019	2.1 %	0.9 %	302	14,237

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM ADHD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	67.4 %	13.4 %	223	330
2021	7.5 %	7.5 %	30	396
2019	21.2 %	14.2 %	101	476

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM MHTX - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	77.5 %	3.4 %	10,561	13,620
2021	72.0 %	2.9 %	12,340	17,149
2019	81.2 %	3.3 %	13,920	17,149

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	9.3 %	0.9 %	102	1,095
2018	8.7 %	0.7 %	136	1,569
2016	7.8 %	0.7 %	111	1,418
2014	9.0 %	0.7 %	162	1,808
2012	11.3 %	0.7 %	253	2,239
2010	14.1 %	0.8 %	304	2,157

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	23.4 %	0.9 %	645	2,761
2019	21.6 %	0.8 %	627	2,900
2017	16.4 %	0.8 %	508	3,091
2015	16.0 %	0.7 %	495	3,096
2013	15.8 %	0.7 %	481	3,036
2011	13.5 %	0.7 %	438	3,247
2007	14.3 %	0.7 %	375	2,625
2005	16.5 %	0.7 %	482	2,923

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS) - Age 10-17

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	18.7 %	3.4 %	1,252	6,704
2021	24.1 %	4.2 %	1,857	7,709
2019	17.5 %	4.3 %	1,347	7,709

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, without health insurance (Uninsured, Formerly NOM 21) - UI

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	19.6 %	3.2 %	2,675	13,620
2021	6.2 %	1.6 %	1,066	17,149
2019	21.5 %	2.5 %	3,689	17,149

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data

	2023
Annual Indicator	5.9
Numerator	870
Denominator	14,830
Data Source	CHCC CareVue EHR, US Census IDB
Data Source Year	2023

NOM UI - Notes:

Percent of children, ages 0 through 17, without health insurance

Data Alerts: None

NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child

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

State Provided Data	
	2023
Annual Indicator	62.1
Numerator	508
Denominator	818
Data Source	CHCC Immunization WebIZ
Data Source Year	2023

NOM VAX-Child - Notes:

Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Alerts: None

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

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

State Provided Data	
	2023
Annual Indicator	80.8
Numerator	11,802
Denominator	14,598
Data Source	CHCC Immunization WebIZ
Data Source Year	2023

NOM VAX-Flu - Notes:

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

Data Alerts: None

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

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

State Provided Data	
	2023
Annual Indicator	95.9
Numerator	4,604
Denominator	4,800
Data Source	CHCC Immunization WebIZ
Data Source Year	2023

NOM VAX-HPV - Notes:

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

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

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

State Provided Data	
	2023
Annual Indicator	97.6
Numerator	4,687
Denominator	4,800
Data Source	CHCC Immunization WebIZ
Data Source Year	2023

NOM VAX-TDAP - Notes:

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

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

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

State Provided Data	
	2023
Annual Indicator	97.5
Numerator	4,679
Denominator	4,800
Data Source	CHCC Immunization WebIZ
Data Source Year	2023

NOM VAX-MEN - Notes:

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

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	9.4	2.1	21	2,224
2021	14.0	2.6	30	2,147
2020	17.9	2.9	38	2,126
2019	20.6	3.1	43	2,091
2018	28.3	3.7	58	2,048
2017	16.1	2.8	33	2,052
2016	27.4	3.7	56	2,047
2015	28.2	3.8	56	1,988
2014	29.6	3.9	59	1,992
2013	35.6	4.2	71	1,996
2012	33.1	4.1	66	1,996
2011	46.3	4.9	90	1,944
2010	57.0	5.4	112	1,965
2009	49.8	4.9	103	2,069

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2023
Annual Indicator	16.9
Numerator	39
Denominator	2,304
Data Source	HVSO, US Census IDB
Data Source Year	2023

NOM TB - Notes:

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

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	23.2 %	2.2 %	104	449

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	48.3 %	17.5 %	265	548
2021	33.8 %	10.6 %	678	2,007
2019	56.5 %	12.3 %	919	1,627

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2024	2.8 %	1.0 %	375	13,620
2021	5.6 %	1.8 %	962	17,149
2019	6.1 %	1.9 %	1,045	17,149

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM FHC - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Northern Mariana Islands

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		56	57	59	61
Annual Indicator	55.5	55.5	57.1	57.1	54.5
Numerator	6,544	6,544	7,415	7,415	5,531
Denominator	11,784	11,784	12,993	12,993	10,143
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021	2024

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	20	56	57	59	61
Annual Indicator	22.7	25.4	65.4	53.1	
Numerator	1,757	1,959	5,047	4,057	
Denominator	7,742	7,721	7,717	7,641	
Data Source	CNMI EHR Pap Exam, International database estimate	CHCC Preventive Visits and US international census	CHCC EHR/RPMS Preventive visits	CHCC CareVue EHR Preventive Visits	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	63.0	65.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator: RPMS query; using ICD-10 and CPT codes plus provider's narrative on preventive visits that include physical and annual exams counseling, screening, well women visits, immunizations and tuberculin skin test, employment health, diabetes and blood pressure check, gynecological exam pap and mammograms of females ages 18-44 who visited CHCC. Denominator: 2020 U.S. International Census Estimates	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Preventive visits included: adult annual and well-women exams, as well as gynecological, and vision or hearing exams; encounters for preventive screening of STDs, mammogram, cancer A1C, body mass index, diabetes, counseling, dental and immunization.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Number of women, ages 18 through 44, who had a preventive medical visit in the past year. (Excluding Emergency Room, and Radiology Department)	

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	96	97	97	98	98
Annual Indicator	74.2	74.2	88.2	88.2	89.4
Numerator	4,288	4,288	5,434	5,434	3,555
Denominator	5,776	5,776	6,158	6,158	3,976
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021	2024

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	98
Annual Indicator	95.7
Numerator	440
Denominator	460
Data Source	NVSS
Data Source Year	2022

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	96	97	97	98	98
Annual Indicator	96.5	93.3	93.7	94.9	93.1
Numerator	877	610	539	449	541
Denominator	909	654	575	473	581
Data Source	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office	CNMI Health and Vital Statistics Office
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	98.0	98.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of infants who were reported by their parents to have been breastfed after birth or prior to discharge at CHCC. Denominator: 2021 HVSO Live birth dataset	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of infants who were reported by their parents to have been breastfed after birth or prior to discharge at CHCC. Denominator: 2022 HVSO Live birth dataset	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Percent of 2023 live births who are breastfed	

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

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

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	4	5	5	6	6
Annual Indicator	1.1	0.4	0	0.5	11.1
Numerator	5	2	0	2	47
Denominator	470	544	419	411	424
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Provisional

Annual Objectives		
	2024	2025
Annual Objective	13.0	15.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of 6 month old infants enrolled in the WIC program who were breastfed exclusively for 6 months. Denominator: Number of 6 month old infants enrolled in the WIC program.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of 6 month old infants enrolled in the WIC program who were breastfed exclusively for 6 months. Denominator: Number of 6 month old infants enrolled in the WIC program.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Percent of infants currently enrolled in the WIC program who were breastfed exclusively for 6 months.	

NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			55	57	59
Annual Indicator	52.7	52.7	43.5	43.5	60.7
Numerator	2,769	2,769	2,393	2,393	2,775
Denominator	5,253	5,253	5,498	5,498	4,572
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019	2021	2021	2024

Annual Objectives		
	2024	**2025**
Annual Objective	61.0	63.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			43	46	49
Annual Indicator	42.4	42.4	39.3	39.3	27.3
Numerator	2,593	2,593	2,156	2,156	1,386
Denominator	6,119	6,119	5,493	5,493	5,072
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021	2024

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			43	46	49
Annual Indicator	18.8	8.1	22	12.1	
Numerator	1,143	503	1,378	749	
Denominator	6,094	6,215	6,256	6,177	
Data Source	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	CareVue,RPMS AND US INTERNATIONAL CENSUS ESTIMATES	
Data Source Year	2019	2020	2021	2022	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	35.0	55.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator: 2019 CHCC RPMS query of Preventive Visit using ICD-10, CPT codes and provider's narratives. Denominator: US International Census estimates of the number of individuals ages 12 to 17 years for 2019	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator: 2020 CHCC RPMS query of Preventive Visit using ICD-10, CPT codes and provider's narratives. Denominator: US International Census estimates of the number of individuals ages 12 to 17 years for 2020	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year. Data Source: RPMS and New CareVue EHR Denominator Number of adolescents, ages 12 through 17 Data source: International Database Estimate, US CENSUS	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year at the CHCC. Data Source: New CareVue EHR Denominator Number of adolescents, ages 12 through 17 Data source: International Database Estimate, US CENSUS	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year at the CHCC. Data Source: New CareVue EHR Denominator Number of adolescents, ages 12 through 17 Data source: U.S. Census International Database (IDB)	

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	20	15	19	15	18
Annual Indicator	13.3	13.3	14.1	14.1	12.5
Numerator	141	141	176	176	138
Denominator	1,059	1,059	1,252	1,252	1,101
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021	2024

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	20	15	19	15	18
Annual Indicator	19.6				
Numerator	54				
Denominator	276				
Data Source	CSHCN Survey				
Data Source Year	2019				
Provisional or Final ?	Provisional	Provisional			

Annual Objectives		
	2024	**2025**
Annual Objective	15.0	25.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Denominator value is based on the total number of surveys completed through the CYSHCN survey. Numerator value is based on the number of families who completed the CYSHCN survey that responded "yes" on the healthcare services they receive for their children being coordinated, ongoing, and comprehensive. The survey is conducted every two years in the CNMI.

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Child Health - All Children

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS) - All Children	
	2023
Annual Objective	
Annual Indicator	8.9
Numerator	1,208
Denominator	13,620
Data Source	MCH-JS-All Children
Data Source Year	2024

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR - Children with Special Health Care Needs

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			52	55	58
Annual Indicator	51.0	51.0	32.8	32.8	70.7
Numerator	183	183	167	167	322
Denominator	358	358	511	511	455
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021	2024

Annual Objectives		
	2024	**2025**
Annual Objective	72.0	74.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR - Adolescent Health - All Adolescents

Federally Available Data					
Data Source: MCH Jurisdictional Survey (MCH-JS) - All Adolescents					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			55	55	55
Annual Indicator	48.4	48.4	46.3	46.3	39.6
Numerator	2,788	2,788	2,306	2,306	2,006
Denominator	5,761	5,761	4,982	4,982	5,072
Data Source	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN	MCH-JS-All Adolescents	MCH-JS-All Adolescents	MCH-JS-All Adolescents
Data Source Year	2019	2019	2021	2021	2024

Annual Objectives		
	2024	**2025**
Annual Objective	51.0	61.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	56.0
Numerator	250
Denominator	447
Data Source	PRAMS
Data Source Year	2022

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS)	
	2023
Annual Objective	
Annual Indicator	75.1
Numerator	411
Denominator	548
Data Source	MCH-JS
Data Source Year	2024

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	67.0
Numerator	167
Denominator	249
Data Source	PRAMS
Data Source Year	2022

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Northern Mariana Islands

SPM 1 - Percent of live births to resident women with first trimester prenatal care.

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	49	51	53	70	72
Annual Indicator	48.8	55.6	66.8	61.7	60.9
Numerator	340	351	382	290	327
Denominator	697	631	572	470	537
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives		
	2024	**2025**
Annual Objective	65.0	75.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator value based on the number of resident live births with prenatal care beginning in the first trimester. Denominator value based on the total number of resident live births.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of deliveries to resident women receiving prenatal care beginning in the first trimester of pregnancy. Denominator: Number of deliveries to resident women in year 2021.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of deliveries to resident women receiving prenatal care beginning in the first trimester of pregnancy. Denominator: Number of deliveries to resident women in year 2022.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Percent of live births to resident or Non-Tourist women with first trimester prenatal care.	

SPM 2 - Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10	15	20
Annual Indicator			2.1	34	49.2
Numerator			2	32	61
Denominator			94	94	124
Data Source			CHCC HUMAN RESOURCES	CHCC HUMAN RESOURCES	CHCC Training Spreadsheet
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	50.0	55.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Numerator: 2 MICAH employees received training on using / entering data into the new electronic health record (CareVue) revenue cycle management (RCM) that was conducted in year 2021, however, due to the challenges presented by COVID-19 pandemic, development of instructional methods to administer training across CHCC PHS staff and MCH serving professionals was postponed to a later date.

Denominator: Number of PHS and MICAH employees

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Numerator: 3 individuals from PHS and 1 person from MCH attended SAS analytic training conducted by CHCC Epidemiologist; 1 employee attended Power BI training in year 2022; 6 attended one key question training; 21 attended breastfeeding bootcamp. Total 32 training participants in 2022.

Other training opportunities were interrupted due to COVID-19 pandemic.

Discussion for providing standardized curriculum for online training to Population Health Staffs including MCH Professionals are ongoing.

Denominator: Number of CHCC PHS and MCH staff and employees.

3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
Denominator reflects the total number of Public Health staff in 2023. The numerator value indicates the unduplicated number of Public Health staff members who completed at least one training related to MCH priorities or activities.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Northern Mariana Islands

ESM WWV.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			5	49	53
Annual Indicator			65.4	53.1	28.6
Numerator			5,047	4,057	2,170
Denominator			7,717	7,641	7,595
Data Source			CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	35.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of females ages 18-44 who received preventive care services at CHCC sites Denominator: Number of women ages 18-44 years (International Database Estimates; U.S. Census)	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of females ages 18-44 who received preventive care services at CHCC sites Denominator: Number of women ages 18-44 years (International Database Estimates; U.S. Census)	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of females ages 18-44 who received preventive care services at CHCC sites Denominator: Number of women ages 18-44 years (International Database Estimates; U.S. Census)	

ESM BF.1 - Percentage of WIC infants who were breastfed at 6 months.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10	57.4	57.6
Annual Indicator			44.6	39.9	43.2
Numerator			187	164	183
Denominator			419	411	424
Data Source			WIC Program	WIC Program	WIC Program
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	57.8	58.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of WIC enrolled infants who were breastfed at 6 months. Denominator: Total number of 6 month old infants in the WIC Program	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of WIC enrolled infants who were breastfed at 6 months. Denominator: Total number of 6 month old infants in the WIC Program	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of WIC enrolled infants who were breastfed at 6 months. Denominator: Total number of 6 month old infants in the WIC Program	

ESM PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			10	15	20
Annual Indicator			0	0	25
Numerator			0	0	2
Denominator			3	8	8
Data Source			MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	25.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of referrals who reported completing at least 75% of the EFNEP program curriculum. Denominator: Number of referrals to the EFNEP program	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of referrals who reported completing at least 75% of the EFNEP program curriculum. Denominator: Number of referrals to the EFNEP program	

ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites

Measure Status:			Active		
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10	1	12.5
Annual Indicator			22	12.1	16.6
Numerator			1,378	749	998
Denominator			6,256	6,177	5,994
Data Source			CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate	CHCC CareVue EHR/US Census International Estimate
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	17.0	19.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator- Number of teens ages 12 through 17 years who accessed preventive care at CHCC sites. Denominator- Number of teens ages 12 through 17 years (US Census International Database Estimate)	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator- Number of teens ages 12 through 17 years who accessed preventive care at CHCC sites. Denominator- Number of teens ages 12 through 17 years (US Census International Database Estimate)	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator- Number of teens ages 12 through 17 years who accessed preventive care at CHCC sites. Denominator- Number of teens ages 12 through 17 years (US Census International Database Estimate)	

ESM MH.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			10	20	30
Annual Indicator			81	81	52.3
Numerator			51	51	45
Denominator			63	63	86
Data Source			F2F Medical Home Survey	F2F Medical Home Survey	F2F Medical Home Survey
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	55.0	60.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of families served by the Family to Family Health Information Center who reported having a medical home. Denominator: Number of families served by Family to Family Health Information Center.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data Source Year: 2021	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of families served by the Family to Family Health Information Center who reported having a medical home. Denominator: Number of families served by Family to Family Health Information Center.	

ESM TR.1 - Percentage of high school students served by SPED who received information on transition

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			10	15	20
Annual Indicator			0	4.9	34.4
Numerator			0	16	115
Denominator			322	329	334
Data Source			Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	35.0	37.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to the unforeseen challenges arising from the COVID-19 pandemic, activities surrounding ESM 12.1 is postponed to a later date. Numerator: Number of high school teens in special education services who received information on transition services. Denominator: Number of high school teens in special education services.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of high school teens in special education services who received information on transition services. Denominator: Number of high school teens in special education services.	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of high school teens in special education services who received information on transition services. Denominator: Number of high school teens in special education services.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Northern Mariana Islands

SPM 1 - Percent of live births to resident women with first trimester prenatal care.
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of pregnant women with first trimester prenatal Care</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of live births by resident women with first trimester prenatal care.</td></tr>
<tr><td>Denominator:</td><td>Total number of live births by resident women.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CNMI Hospital records, CNMI HVSO data</td></tr>
<tr><td>Significance:</td><td>Early and adequate prenatal care is vital to ensuring a healthy pregnancy. Receiving inadequate prenatal care increases the risk for complications and other adverse outcomes for both mother and baby. Early and adequate prenatal care provides the opportunity for early detection and management of complications which reduces the risk for pre-term labor and babies being born with low birth weight. According to the 2015 CNMI MCH Needs Assessment, almost 70% of deliveries in 2013 received inadequate prenatal care and 6% received no prenatal care at all.</td></tr>
</table>

SPM 2 - Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	By 2025, increase the number of CHCC Public Health staff (PHS) and MCH serving professionals who complete training on MCH priorities and topics by 25% from baseline.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CHCC PHS staff and MCH serving professionals who completed training on MCH priorities and related topics. **Denominator:** Number of CHCC PHS staff and MCH serving professionals
Data Sources and Data Issues:	Health Department/CHCC Administrative Records.
Significance:	A skilled workforce is critical for rapidly changing and emerging public health issues. It is important for health department employees, especially those serving MCH populations, to posses the knowledge and skills to effectively work towards improving the health outcomes and life trajectories of the women and children we serve.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Northern Mariana Islands

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Northern Mariana Islands

ESM WWV.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.
NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Measure Status:	Active
Goal:	The goal is to increase the number of women ages 18-44 accessing preventive medical services at CHCC
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women ages 18-44 years accessing preventive health services at CHCC **Denominator:** Number of women ages 18-44 years
Data Sources and Data Issues:	The data source: Numerator - CareVue EHR including those who all visited the CHCC health department/clinics, and MICAH internal and external partners during the past year. Denominator: - International Database, U.S. Census
Evidence-based/informed strategy:	ESM 1.1 measures the number of women ages 18-44 years who access preventive care visit at CHCC. Data source includes Electronic Health Record and Records of Outreach Events that provides information on activities involving expanding clinical hours, and utilization of the mobile clinic to improve access to health care service
Significance:	Evidence suggests that expanded hours increases access and provides opportunities for working women and others with schedule challenges to access care.

ESM BF.1 - Percentage of WIC infants who were breastfed at 6 months.
NPM – A) Percent of infants who are ever breastfed B) Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Breastfeeding, Formerly NPM 4) - BF

Measure Status:	Active
Goal:	Increase of the number of infants breastfed through 6 months
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of infants who were 6 months breastfed.</td></tr><tr><td>**Denominator:**</td><td>Total number of infants</td></tr></table>
Data Sources and Data Issues:	Women Infant and Children (WIC) program will provide data on infants ever breastfed
Evidence-based/informed strategy:	Information on Breastfeeding rate at 6 months can be obtain through the WIC dataset, strategies include enhancing community awareness on breastfeeding, reinforcing workplace breastfeeding policy and providing support on breastfeeding supplies for families accessing hospital and clinic services would likely increase breastfeeding rate in all categories.
Significance:	Although the goal is for mothers to exclusively breastfed their infants through 6 months, achieving this task is difficult specially if the population is showing a 6 months exclusively breastfed rate of 0% to 2% annually. Supporting mothers to breastfeed and targeting a period where we see drops in breastfeeding (around the timing for when most working mothers return to work) is critical for increasing the likelihood of longer breastfeeding duration. Studies have shown that mothers who are working full-time outside of the home is related to a shorter breastfeeding duration.

ESM PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.
NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity - Child, Formerly NPM 8.1) - PA-Child

Measure Status:	Active
Goal:	Increase enrollment in an evidence-based nutrition and physical activity program.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of referrals who reported completing at least 75% of the EFNEP program curriculum. **Denominator:** Number of referrals to the EFNEP program
Data Sources and Data Issues:	Data source: MCH Referral Logs
Evidence-based/informed strategy:	Referrals to an evidence-based nutrition and physical activity program (EFNEP) can be made during Well child visits at CHCC outpatient clinics (Children's Clinic, Mobile Clinic, RHC, THC) which supports an evidence-based Eating Smart Being Active curriculum that teaches children healthy lifestyle choices, nutrition, physical activity including food preparation.
Significance:	Medical providers play a critical role in obesity prevention through communicating early body mass index screening results to parents and helping them to adopt key behavioral changes in diet and physical activity. The well-child visit and evidence-based program on healthy eating and physical activities are essential at addressing obesity prevention,

ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Measure Status:	Active
Goal:	The goal is to reduce youth suicide rate among adolescent by working with Providers to increase preventive care visits that provides behavioral health screenings and assessments.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number adolescent ages 12 through 17 who receive prevent care visit at CHCC sites **Denominator:** Total number adolescent ages 12-17 years.
Data Sources and Data Issues:	Numerator: CareVue EHR Denominator: International Database U.S. Census
Evidence-based/informed strategy:	The ESM measures the the number of adolescent ages 12 through 17 years who access preventive care visits and allow providers to conduct behavioral/mental health screening, and assessment focused on improving the patient's health and well-being holistically.
Significance:	The adolescent well-visit is an opportunity for adolescents to receive healthcare, counseling, and guidance to help teens identify and adopt or modify behaviors to avoid damage to health, effectively manage chronic conditions, or to prevent disease. Adolescent healthcare is critical for establishing lifelong healthy behaviors and prepares adolescents for transition into adult healthcare.

ESM MH.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Measure Status:	Active
Goal:	The goal is to increase access to peer support available through the CNMI Family to Family Health Information Center for parents to receive information and assistance on accessing a medical home in the CNMI.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families served by the Family to Family Health Information Center who reported having a medical home. **Denominator:** Number of families served by Family to Family Health Information Center.
Data Sources and Data Issues:	Data will be obtained through program administrative records/referral forms.
Evidence-based/informed strategy:	F2F Survey provide information on the number of clients who reported having having a medical home; F2F program provide support to reduce isolation, shame and blame, and assist parents in navigating child serving systems, including access to medical homes.
Significance:	Family Peer Support is the instrumental, social and informational support provided from one parent to another in an effort to reduce isolation, shame and blame, to assist parents in navigating child serving systems, including access to medical homes.

ESM TR.1 - Percentage of high school students served by SPED who received information on transition
NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care (Transition, Formerly NPM 12) - TR

Measure Status:	Active
Goal:	The goal is to utilize school based presentations to increase awareness and knowledge regarding the importance of and process of transition into adult healthcare.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of high school students served by SPED who received information on transition **Denominator:** Number of high school students served by SPED
Data Sources and Data Issues:	CSHCN presentation dataset
Evidence-based/informed strategy:	Number of adolescents and families who attended healthcare transition presentation that aims to enhance awareness to the importance of transition/referral to another provider, managing medical needs, and knowledge about health continuity.
Significance:	Healthcare transition is defined by the American National Alliance to advance adolescents healthcare as the process of changing from a pediatric to an adult model of health care. This is critical for ensuring continuity of care and prioritization of key factors for health improvement. The benefits of transition include preparing the adolescent early for taking responsibility for his care by knowing his own condition, progress, medications and possible disease outcome.

Form 11
Other State Data

State: Northern Mariana Islands

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Northern Mariana Islands

Annual Report Year 2023

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Quarterly	2		
2) Vital Records Death	Yes	Yes	Annually	12	Yes	
3) Medicaid	Yes	No	Annually	12	No	
4) WIC	Yes	No	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	12	No	
6) Newborn Hearing Screening	Yes	Yes	Daily	1	Yes	
7) Hospital Discharge	Yes	Yes	Monthly	12	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	12	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Northern Mariana Islands

Annual Report Year 2023

Products and Publications information has not been provided by the State.