Maternal and Child Health Services Title V Block Grant

Northern Mariana Islands

FY 2023 Application/ FY 2021 Annual Report

Created on 8/11/2022 at 7:58 AM

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I. General Requirements

I.A. Letter of Transmittal

Commonwealth Healthcare Corporation
Commonwealth of the Northern Mariana Islands
1 Lower Navy Hill Road Navy Hill, Saipan, MP 96950

CEO-L22-898

July 25, 2022

Christopher Dykton
Acting Director, Division of State and Community Health
Maternal and Child Health Bureau, HRSA
US Department of Health & Human Services
5600 Fisher Lane Rockville, MD 20857

Subject: **HRSA Announcement No. HRSA-23-001 / Tracking No. 202530**

Dear Mr. Dykton,

The Commonwealth of the Northern Mariana Islands' (CNMI) Commonwealth Healthcare Corporation (CHCC) is pleased to submit the FY 2023 Title V Block Grant Application /FY 2021 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,

Esther Lizama Muña, PhD, MHA, FACHE
Chief Executive Officer
State/Territorial Public Health Official
Commonwealth Healthcare Corporation, the Territorial Hospital & Health System

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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 F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

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 Maternal, Infant, Child and Adolescent Health (MICAH) Administrator designated as the Project Director. 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 assist with data collection and analysis. The MCH program worked with partners and stakeholders to identify the state'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. Final selection of priorities was based on programmatic capacity, evidence-base, cost, and ability to make a 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 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, an MCH survey conducted in 2021 indicated that just **57% of women ages 18-44 years reported completing an annual preventive visit.** 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: 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 baseline the baseline of 55%.
Strategy: Expand access: Outreach and/ or increased clinic hours.
For FY2023, the CHCC PHS will conduct the following activities to improve women's health:

- **Utilize the CHCC mobile clinic to provide access 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, 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. In 2020, **first trimester prenatal care was at 56% and in 2021 increased to 67%.** Infant mortality was at 12.2 per 1,000 live births in 2021. Because CNMI does not have a level III neonatal intensive care unit, this priority will be a State Performance Measure (SPM) evaluated by prenatal care.
Priority Need: 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 FY2023, the CHCC PHS will conduct the following activities to improve breastfeeding rates:

- **Expand workplace breastfeeding support**
- **Conduct community awareness regarding the importance of breastfeeding for infant health**
- **Support breastfeeding supplies for families accessing hospital and clinic services**

Priority Need: 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 FY2023, the CHCC PHS will conduct the following activities to improve prenatal care rates:

- **Service coordination for prenatal patients (support to address access challenges, i.e. uninsured assistance, transportation vouchers, etc.)**
- **Expand partnerships with the WIC and Family Planning clinics to increase early prenatal care rates**

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. YRBS data shows that less than half of students eat breakfast every day. It is known that expensive nutrition rich foods are replaced with high-calorie, high-fat, high-sodium options. In addition, 31.5% of input survey respondents do not believe children of the CNMI have access to healthy physical activities. YRBS activity data shows that only half the students played at least one sport in the past year. In addition, an increasing number of middle school students, 31%, self-report being overweight. 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. Although 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: 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: Enhance partnerships with CNMI youth serving agencies or organization to provide more opportunities for physical activity among children 6 through 11 years.

For FY2023, the CHCC PHS will conduct the following activities to improve rates of physical activity among children 6 through 11 years:

- **Increase the number of parents/caregivers enrolling in evidence based nutrition and physical activity curriculum/programs to build capacity among families to address nutrition and physical activity needs.**
- **Conduct community awareness and health promotion activities to promote physical activity for children ages 6 through 11 years.**

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, YRBS data shows an increase in suicidal thoughts among teens. Suicide prevention was also ranked high for feasibility and impact as well as program capacity to affect change. 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.

Priority Need: 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: Work with partners to increase the number of adolescents accessing adolescent health visits.

For FY2023, the CHCC PHS will conduct the following activities to support coping skills and suicide prevention for adolescents:

- **Work with pediatric providers to implement evidence based behavioral health screenings during teen wellness visits**

Priority Need: 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 64% 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 FY2023, 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: 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 14%.

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

For FY2023, the CHCC PHS will conduct the following activities to improve the percentage of CSHCN that report having a medical home:

- **Strengthen partnerships with the CNMI Disability Network Partners (DNP) to establish referral mechanisms to connect CSHCN to medical homes**

SYSTEMS BUILDING Building workforce capacity to improve the maternal and child health services in the CNMI was chosen as the priority. 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 in your area. 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: Professionals have the knowledge and information to address the needs of maternal and child health populations

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

Objectives: By 2025, at least 50% of CHCC PHS staff will have completed training related to at least 75% of the CNMI MCH Title V population health domains.

Strategy: Provide training to CHCC staff and other MCH serving professionals.
For FY2023, 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

Clinical Champions for CNMI Maternal & Child Health Populations

The CNMI continued to experienced challenges stemming from the COVID-19 pandemic. As a unit within the health department, MICAH staff, along with other health department staff, were in the forefront in response activities. When vaccines became available, MICAH staff members served in leading capacities to ensure successful implementation in the CNMI.

Part of this work resulted in strengthened partnerships with clinical champions from our CNMI OB/GYN and Pediatrics department, namely with Pediatrics department chairwoman, Dr. Sadie LaPonsie and Family Planning medical director, Dr. Maria Hy.

Pediatric Partnership Activities

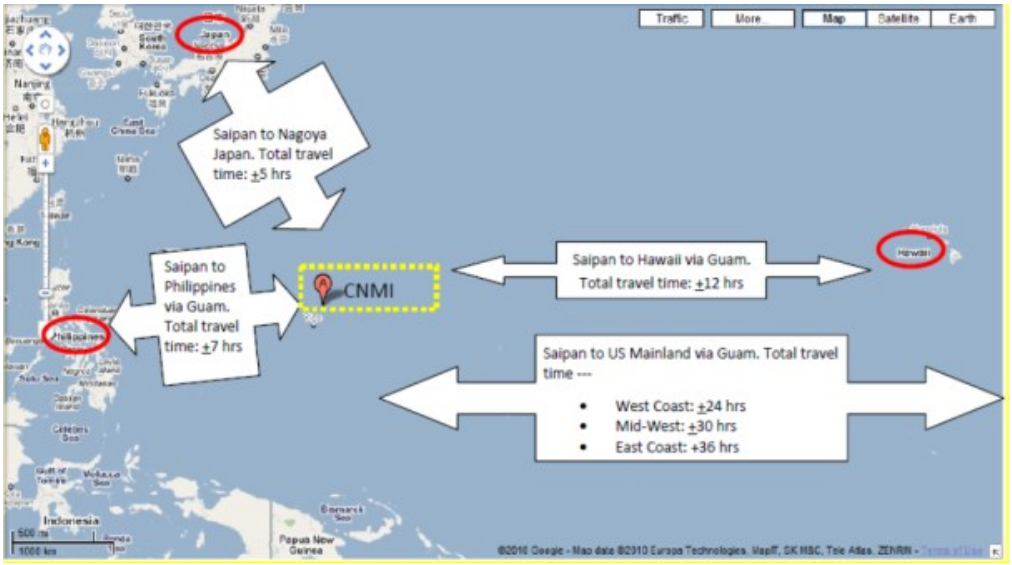
- Implementation of COVID-19 vaccinations for children seen during clinic visits.
- Community awareness videos to highlight trusted messengers (pediatricians) in promoting COVID-19 vaccinations among children.
- Integration of public health programs during monthly high-risk perinatal case conference sessions.
- Development of project plan and proposal to implement activities addressing pediatric mental health and mental healthcare access.
- Facilitation of the CNMI Public School System parent stakeholder virtual meeting to address questions families had about COVID-19 vaccinations with over 250 stakeholders in attendance.

OB/GYN Partnership Activities

- Implementation of COVID-19 vaccinations for women seen during Women's Clinic visits.
- Community awareness videos to highlight trusted messengers (OB/GYNs) in promoting vaccinations among pregnant women.
- Advocate for integrating MCH staff into the Women's Clinic with the MCH Service Coordinator now stationed at the Women's Clinic. This has resulted in seamless coordination between clinical care and MICAH programs/services for high risk patients.
- CNMI 2021 Women's Health Month Doc Talk presentation focused on prevention, screenings and other women's health topics.

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. In February of 2020, a reorganization of the CHCC was undertaken. The CHCC operations is now organized under eight (8) sections: Nursing, Medical, Finance, Population Health Services, Hospital, Tinian Health Center, Rota Health Center, and Dialysis Center. The CNMI MCH Title V Program falls with the Population Health Services section and administered under the oversight and direction of the Director of Population Health Services.

Demographics

According to the 2010 U.S. Census, the population of the Commonwealth of the Northern Mariana Islands (CNMI) is 53,883. This reflects a 22.2 percent decline (15,338) between 2000 and 2010. This trend contrasts the previous decade, when the CNMI's population increased by 59.7 percent to 69,221 residents. Today the majority of the population resides on the island of Saipan 48,220, followed by Tinian with 3,136 (6 percent), then Rota with 2,527 (5 percent). By age group, the largest proportion of the decline is among women between ages 20 and 34 (26 percent). This may be due to the closing of

garment factories on Saipan since 2000 that employed a majority of temporary workers from abroad.

Single ethnic groups that accounted for the majority population in the CNMI were identified as Filipino (35 percent), followed by Chamorro (24 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. Native Hawaiian and Other Pacific Islanders made up about 35 percent and Caucasians less than 2 percent. About 13 percent of CNMI's population were of two or more ethnic origins or races.

Table 1: MCH Population

Population	1990	2000	2010
Infants (less than 1)	824	1,297	1,138
Children (1-12)	8,372	12,701	11,124
Adolescents (13-17)	2,709	3,735	4,372
Women (15-44)	13,669	25,836	12,522

Source: U.S. Census Bureau

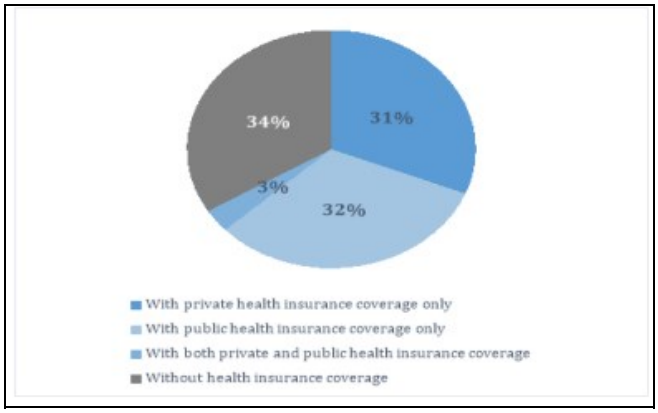
Table 2: CNMI Population by Ethnicity

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

Source: U.S. Census Bureau

CNMI has a large percentage of the population that are uninsured. The 2010 U.S. Census reports the uninsured population in the CNMI at 34 percent, more than double the 15 percent uninsured rate in the United States. 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 2010 US Census data, residents with Medicaid constitute 32 percent of the population, double the Medicaid rate of the U.S. at 16 percent.

Figure 1. Insurance Coverage in the CNMI- 2010 US Census



Source: US Census Bureau

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. Detailed demographic and ethnicity data is pending release as of the date of this report. 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 Rota, Tinian, and Saipan, respectively.

Table 3. 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

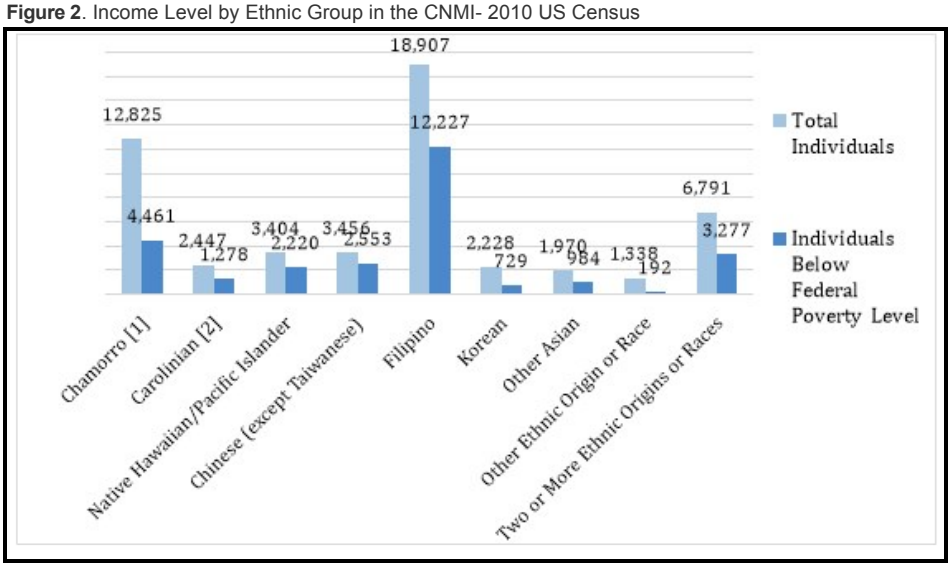
Source: US Census Bureau

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. As a result of this confluence, the CNMI government's revenues have fallen drastically causing the CNMI's annual budget to drop 56 percent - more than $90 million dollars, over the last 12 years. As such, many jobs have been lost resulting in many people without the financial means, education, and experience needing to relocate to the U.S. mainland. According to the 2010 U.S. Census, 4,061 families in the CNMI had an income that was below poverty level with related children under 18 years old. Approximately 52 percent of the total population lived below the federal poverty level. Specifically, 11,693 individuals were living below 50 percent of poverty level, 32,885 individuals below 125 percent of poverty level and 40,368 individuals below 185 percent of poverty level. Approximately 65 percent of the Filipino population, the largest ethnic group, were living below the poverty line. Updated poverty data for the CNMI gathered through

the 2020 US Census is pending as of the date of this report.

Figure 2. Income Level by Ethnic Group in the CNMI- 2010 US Census



Source: US Census Bureau

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 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 2021, the CHCC had over 1,000 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 seven pediatricians and two mid-level pediatric providers 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 Systems 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, during the 2020-2021 school year, there were 127 infants and toddlers served by the Early Intervention Services program, 132 enrolled in the Early Childhood Special Education program, and 962 enrolled in the Special Education program[i].

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. There were a total of 159 referrals made to the Early Intervention program, with 68 qualifying for services of which 55 were identified with a developmental delay and 13 were qualified due to an established condition.

Rota Health Center

The Rota Health Center is the only medical facility on the island of Rota and services the entire population of roughly 1,800. At present the Rota Health Center has one mid-level provider, five nurses, two laboratory technicians, three pharmacy technicians, two x-ray technicians and one dental assistant. 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 mid-level providers, ten nurse, one phlebotomist, one radiology technician, one pharmacy technician, and one dental assistant. 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.

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.

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 Population Health section. 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 2010 U.S. Census, administered prior to the implementation of the Patient Protection and Affordable Care Act (PPACA), reports the CNMI uninsured population at 34 percent, more than double the 15 percent of uninsured in the US. 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 rate of the uninsured has not been reassessed since this law was passed but has likely increased after this policy change. As of the date of this report, the CNMI is currently waiting for updated data on uninsured population rates for the CNMI from the US Census Bureau through data that was collected from the 2020 US Census.

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

Treatment services, including access to diagnostic services, not readily available in the CNMI are handled through 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[ii]. 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. Together, the tourism and garment manufacturing industries accounted directly and indirectly for about 80 percent of all employment in the CNMI in 1995 and made up a large part of the government revenues[iii]. The economic condition of the CNMI during the early 2000s is one in which many individuals were out of employment and the government had little to no means of extending support or relief to community members in response to the economic crisis. 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[iv].

Data from the CNMI Medical Referral Program for 2021 indicates that 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. For the CNMI, that fixed percentage is 55 percent. 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. Moreover, the CNMI receives a relatively low fixed percentage, which is known as the Federal Assistance Percentage, or FMAP. The FMAP rate for the CNMI is and historically has been lower than most of the 50 states. 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 provided the CNMI is not based on per capital income of residents, thus the territories' FMAP does not reflect the financial need of the CNMI in the same ways that the 50 states' financial needs if represented. 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.

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 has exhausted the additional funds made available by the PPACA in April 2019. As a result of this, all healthcare for Medicaid population has been directed towards the CHCC, away from private clinic providers. The CHCC Women's and Children's clinic has experienced an influx of patients due to this policy resulting in clinic appointment availability extending from one and half to two months out.
In general, once the CNMI exhausts the federal Medicaid and CHIP allotments, the territory must fund the program with local funds. 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.

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 Centersof 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."

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[i] CNMI Public School System. (2020). Commonwealth of the Northern Mariana Islands Public School System 2019-2020 Fast Facts and Figures. Retrieved on August 10, 2021 from https://www.cnmipssoare.org/application/files/8815/8031/8258/SY_2018-2019_CNMIPSS_Annual_Report_1.24b_ForPrinters.pdf

[ii] 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

[iii] Office of the Governor, Commonwealth of the Northern Mariana Islands. (2008). Economic Impact of Federal Laws on the Commonwealth of the Northern Mariana Islands. Retrieved on August 26, 2018 from https://marianaslabor.net/news/economic_impact.pdf

[iv] 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 2023 Application/FY 2021 Annual Report Update

Annual Needs Assessment Update

COVID-19

As of July 07, 2022, the total reported COVID-19 cases in the CNMI were 11,819 with 35 COVID-19 related deaths since the start of the pandemic. Approximately 99 percent of the population aged 5 years and older have completed primary vaccinations against COVID-19, and about 52.2 percent of the population ages 5 years and older have received a booster shot. On June 27, 2022, the CNMI implemented COVID-19 vaccinations for children as young as 6 months old as authorized for emergency use by the FDA and CDC.
The COVID-19 pandemic has posed significant challenges across the various infrastructure systems within the Northern Mariana Islands and has had a tremendous impact on tourism, the major source of revenue for the territory resulting in significant reduction in revenue and unemployment across service industry workers. Tourism from Asian countries had major declines at the beginning of the pandemic in January of 2020 with visitor arrivals declining by 85 percent in March of 2020 compared to the year prior. Visitor arrivals declined from 653,150 in fiscal year 2017 to just 5,365 in fiscal year 2021. According to the CNMI Prevailing Wage Study (PWS), the reported number of employees earning less than $8 per hour declined by 68 percent from 2019 to 2021[1]. The decline, as noted by the US Government Accountability Office (GAO) is largely due to the economic hardship during the COVID-19 pandemic and to lower study participation by private businesses. As the territory's department of health, the Commonwealth Healthcare Corporation (CHCC) worked swiftly to engage partners from all sectors of government, including private organizations, in response efforts against COVID-19. Effective communication strategies, one stop COVID testing and treatment centers, and coordination across various sectors were implemented to protect public health.

On-going Needs Assessment Activities

MCH continues to collect and analyze data through the various programs under the CNMI MICAH, CHCC hospital, CNMI Health and Vital Statistics Office, and other partners such as the CNMI Public School System and WIC.

Participation in partner meetings, workgroups, and councils allows the program to interact with stakeholders and gather valuable qualitative information that is used to further guide program activities.

In addition, membership on 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 the opportunity to network with agency partners for obtaining updates on annual plans, objectives, needs, and any emerging issues occurring through partner programs.

MCH conducts a monthly review on Health & Vital Statistics Data, periodic review of hospital admissions data, and conducts chart reviews to help inform ongoing needs assessment processes.

The MCH Jurisdictional survey was implemented in 2020 in the CNMI, providing additional data source for gathering 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) that the CNMI did not have sources for. Second round of the survey was conducted in November of 2021.

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 reducing health problems among mothers and babies. Data collection for sampled birth records will begin in July 2022 and data from the PRAMS will be used in future MCH needs assessment activities.

Update on Health Status/Needs of MCH Population

Women/Maternal Health

Data gathered from the MCH Jurisdictional Survey (MCH-JS) in 2021 indicates that an estimated 57.1 percent of women ages 18 thru 44 years reported completing a preventive health visit in the past year, which is a slight increase from 2019 data of 55.5 percent. Additionally, review of the number of pap smears processed through the Diagnostic Laboratory Services (DLS) in Honolulu show increases in the number of cervical cancer screenings being conducted in the CNMI, with 2,682 pap specimens processed at DLS in 2021 compared 1,895 in 2020. The number of women accessing Family Planning services had increased in 2021 compared to the year prior and the percentage of live births to women accessing early prenatal care increased from 55 percent in 2020 to 67 percent in 2021.

Perinatal/Infant Health

There were 575 live births in the 2021 in the CNMI with approximately 75 percent of the births covered by Medicaid. Approximately 94 percent of infants were breastfed, however less than 1 percent of infants were breastfed exclusively through 6 months. In 2021, 8.2 percent of infants were born with low birthweight, a decrease from 10.4 percent from the year prior and the percent of infant born preterm was 8.9 percent, slightly lower than 10.9 from the year prior. The CNMI informality rate for 2021 was 12.2 per 1,000 which increased from 7.6 in 2020.

Child Health

In 2021, data from the MCH-JS indicates that just 43.5 percent of children ages 6 through 11 years were reported to be physically active at least 60 minutes per day, a decrease from prior survey data of 52.7 percent. The percentage of children who were reported with decayed teeth or cavities on the MCH-JS also increased from 13 percent in 2020 to 17 percent in 2021, however there was an increase in the percentage of children reported to have accessed preventive dental care, with 46.4 percent of children ages 1 through 17 years reporting having a preventive dental visit in the past year. This is an increase from 31.5 percent from the 2019 MCH-JS survey.

The percentage of parents in 2021 that reported their children (ages 0 through 17 years) to be in excellent or very good condition was 72 percent, a decrease from the 2020 percentage of 81.2 percent and significantly lower than the US national percentage of 90.4 percent.

Vaccination coverage among CNMI children ages 19 through 35 months for the combined 7-vaccine series was 70 percent in 2021, similar to the 2020 percentage of 71.5.

Adolescent Health

CNMI 2021 Maternal and Child Health Jurisdictional Survey data on the adolescent well-visits indicate that just 39.3 percent of adolescent ages 12 through 17 years had a preventive visit in the past year, a slight decrease compared to the 2020 percentage of 42.4 percent. Teen births continue to decline with a rate of 13.0 per 1,000 in 2021, a decline from 15.1 per 1,000 in 2020 and 21.0 per 1,000 in 2019. Vaccinations among the CNMI adolescent population are also maintaining high coverage with 95.5 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 97.7 percent receiving at least one dose of the Tdap vaccine.

As of the date of this report, the CNMI was awaiting the results of the Youth Risk Behavioral Survey (YRBS) that was administered in 2021.

Children with Special Health Care Needs (CSHCN)

According to the MCH-JS, the CNMI has an estimated 7.3 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 CNMI MCH Jurisdictional Survey indicated that only 14.1 percent of CSHCN, ages 0 through 17 in 2021 reported having a medical home, significantly lower than the US percentage of 42.2 percent[2]. Additionally, 32.7 percent of families of 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, 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. The Fiscal Specialist is currently serving as the MICAH Program Administrator until a permanent staff member is identified for the position.

In April of 2022, the Child Health Coordinator, who also served as the CSHCN Project Director, had 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 is anticipated to be completed by the end of FY2022.

During the COVID-19 pandemic response in FY2021, the MICAH Administrator/Title V Project Director served as the COVID-19 Vaccinations Operations Lead as part of the CHCC emergency response structure. Other staff members, including the MCH Services Coordinator and Newborn Screening Coordinator were also assigned to COVID-19 vaccination operations.

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 department and 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 child care 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 provides training to child care providers on developmental screening.

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, CNMI Office of Vocational Rehabilitation, and Developmental Disabilities Council are the agencies that form that core group of the 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 MCH Bureau. The DNP meet on a quarterly basis and work on projects such as the CNMI Disability Resource Directory, and the Annual Transition Conferences.

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 2021)

No changes to Title V priority selections were made in FY2022. However, a change in strategy for the child health domain was made. The strategy of improving well-child visits as a mechanism for improving physical activity and addressing obesity related issues among children 6 through 11 years is replaced with the strategy to increase the number of families enrolling into evidence based nutrition and physical activity programs or curriculum.

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

At the end of FY2021, the Chief Operations Officer, Subroto Banerji, had left the CHCC. The position remained vacant for several months until a replacement was identified in the Spring of 2022.

A major organizational change was the transfer of the CNMI Medical Referral Program to the CHCC. In January of 2022, the CNMI Medical Referral Program was transferred from the Office of the CNMI Governor to the CHCC. The Medical Referral Program is designed to provide residents of the CNMI, inclusive of the MCH populations and CSHCN, access to medical care that is not available in the CNMI. Currently, the CHCC is undergoing a review, revision, and developing policies and procedures to streamline medical referral reviews and processes to more effectively meet the health needs of the CNMI population. With improved program processes, the organization anticipates improvements in financial performance, processes for accessing off-island care, and an opportunity to identify and implement actions to improve sustainability of the program. While there are identified areas of opportunity and potential for improving healthcare access with this transition, it must be noted that the transfer comes with a risk of financially liability. The Medical Referral Program has historically operated underfunded, with an annual appropriation of $2 million a year and annual spending of $15 million to $18 million.

Emerging Public Health Issues

The COVID-19 pandemic continues to be a public health priority in the CNMI. The first wave or surge of COVID-19 cases in the CNMI occurred in November 2021, almost 2 years since the pandemic began. Thus, the surge occurred at a time when a vast majority of the CNMI population had been fully vaccinated and therapeutics available for treatment. However, the CNMI maintains vigilant in monitoring the pandemic as the situation evolves and new variants identified. Additionally, other threats in infectious diseases that may threaten the MCH population continued to be monitored, such as the Monkeypox outbreak, which was just determined by the World Health Organization as a Public Health Emergency of International Concern in July 2022.

[1] United State Government Accountability Office. (2022). Commonwealth of the Northern Mariana Islands Recent Workforce Trends and Wage Distribution. Retrieved on July 07, 2022 from https://www.gao.gov/assets/gao-22-105271.pdf

[2] Maternal and Child Health Bureau. (2020). 2019-2020 National Survey of Children's Health. Retrieved on July 29, 2022 from https://www.childhealthdata.org/browse/survey/results?q=8569&r=1

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

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$457,947	$463,007	$463,450	$465,091
State Funds	$0	$0	$0	$0
Local Funds	$0	$0	$0	$0
Other Funds	$469,527	$425,131	$474,700	$517,315
Program Funds	$0	$0	$0	$0
SubTotal	$927,474	$888,138	$938,150	$982,406
Other Federal Funds	$1,657,040	$664,388	$2,059,790	$3,047,227
Total	$2,584,514	$1,552,526	$2,997,940	$4,029,633

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

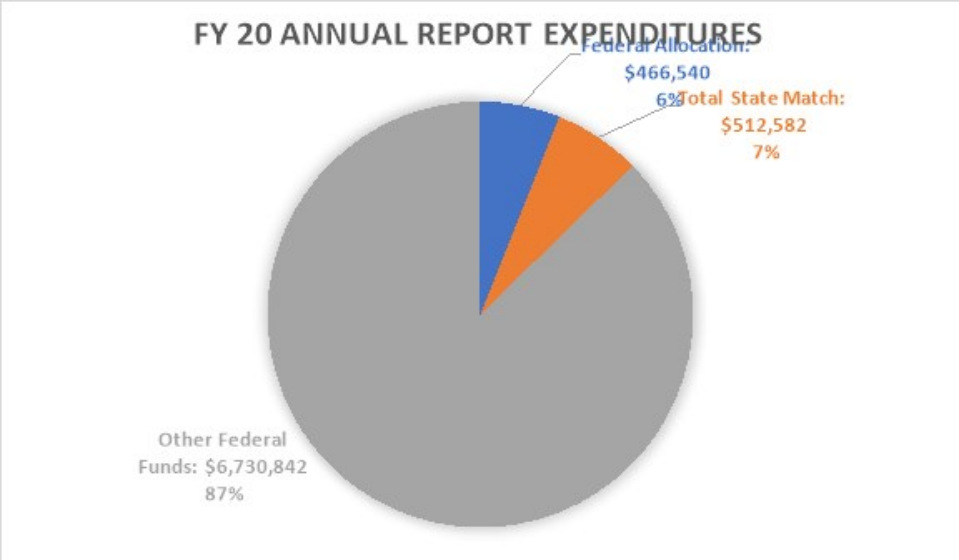
	2023	
	Budgeted	Expended
Federal Allocation	$466,540	
State Funds	$0	
Local Funds	$0	
Other Funds	$479,204	
Program Funds	$0	
SubTotal	$945,744	
Other Federal Funds	$7,930,007	
Total	$8,875,751	

III.D.1. Expenditures

Overview of Expenditures:

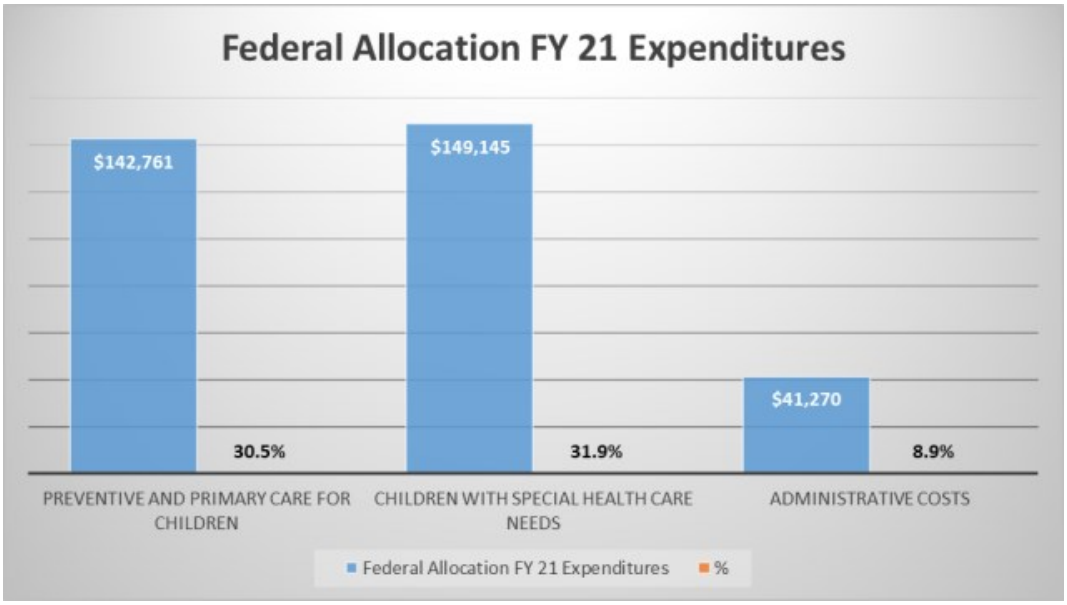
The mission of the CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and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

During the Project Year 2021, from 10/01/2020 through 08/02/2022, the MCH Program expended total funds of $317,074. As of August 2, 2022, the current encumbrance figure is $26,729 and the total unobligated amount is $122,737. Of the total unobligated amount of $60,619 is allocated for Wages, Salary and Fringe Benefits, $19,239 is allocated for Administrative Costs, and then remaining funds of $42,879 is allocated for travel, professional services, supplies and other categories. Therefore, the program is projecting to expend all funds under the grant award by the end of the project and budget period.



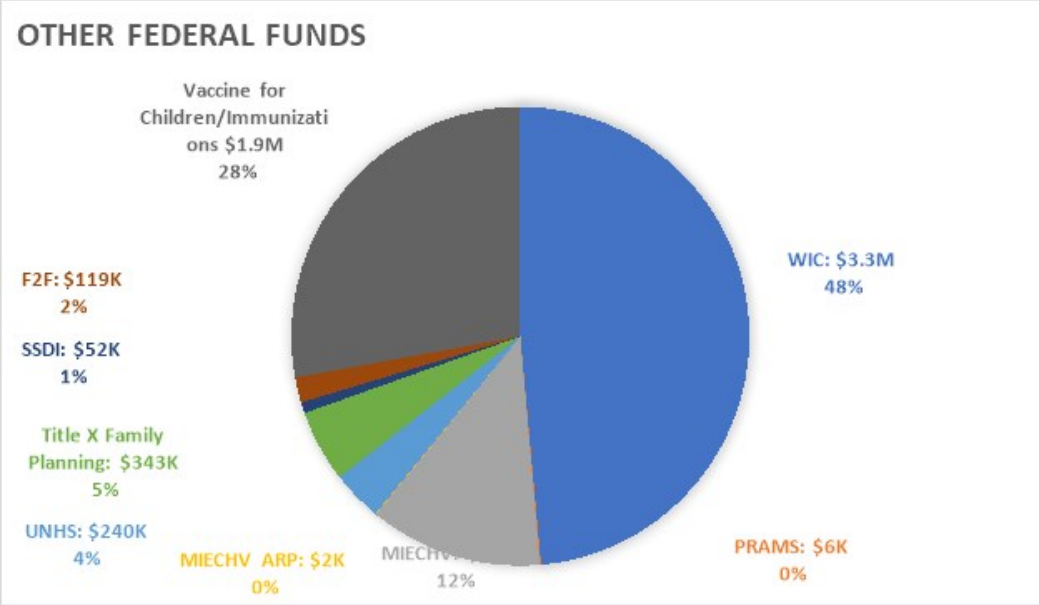
Legislative Requirements Met:

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 Fiscal Specialist who is also in the acting capacity as the MICAH 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 Fiscal Specialist/Acting MICAH 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, *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 21. The chart below provides an overview of the required federal allocation for the FY 21 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 $6,730,842.



Total State Match:

The Total State Matching funds in the amount of $512,582 was expended for FY 2021. 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

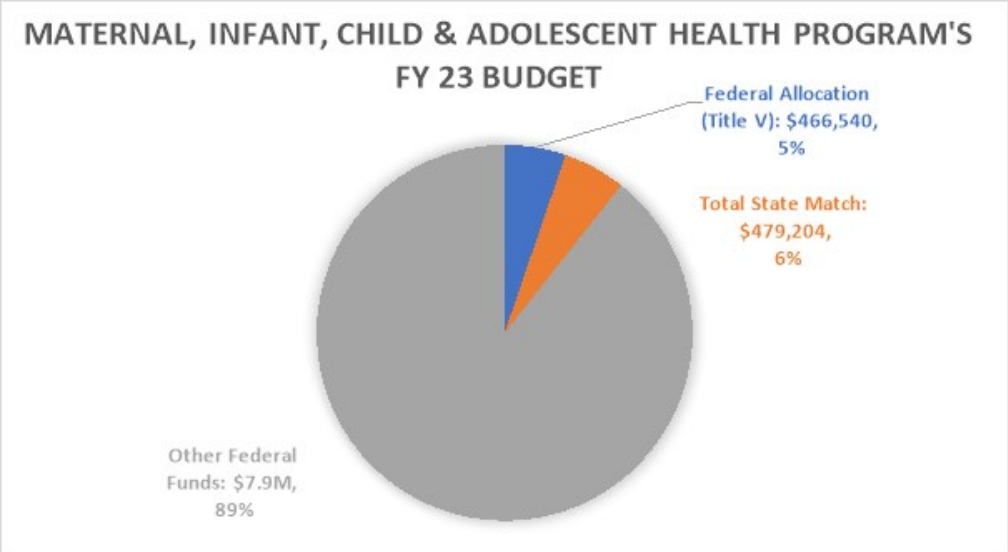
Budget Overview:

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 2023 estimating a total state MICAH Programs budget of $8.9M.

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 Administrator, MICAH Services Coordinator, 2 Early Intervention Services Workers, and a Caseworker. In addition, the MCH Program cost shares with other MICAH federal program funds to support the following staffing: the Fiscal Specialist, Health Promotion Specialist and the MICAH Administrative Specialist. The Title V funds also support 50% of the Population Health Services Director's FTE who serves as the Project Director for the MCH Title V Block Grant. The Fiscal Specialist is funded 50% under the Title V funds, 45% under the ACA Maternal, Infant Early Childhood Home Visiting funds and 5% under the Family Professional Partnership/CSHCN funds. The Health Promotion Specialist is funded 20% under the Title V funds and 80% under the Immunization and VFC Program funds. The MICAH Administrative Specialist is funded 30% under the Title V funds and 70% under the ACA Maternal, Infant Early Childhood Home Visiting funds.

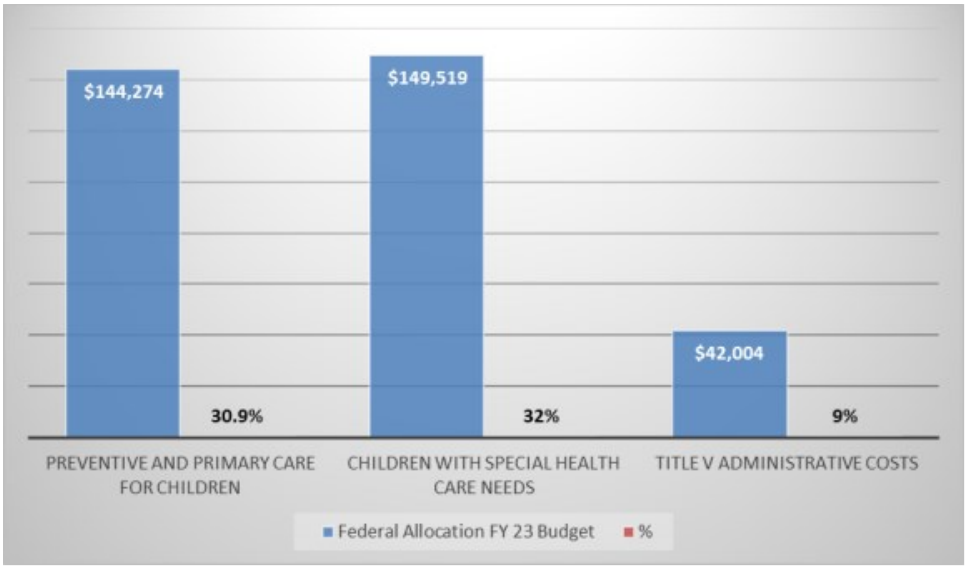
In addition to personnel salaries and fringe benefits, the Title V funds are budgeted towards Public Education and Awareness, Supplies and All Other Costs to support the MCH Programs activities and initiatives stated on the State Action Work Plan. For instance, public education and awareness costs include 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, immunization, 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 2023 Budget as reported on Form 2.



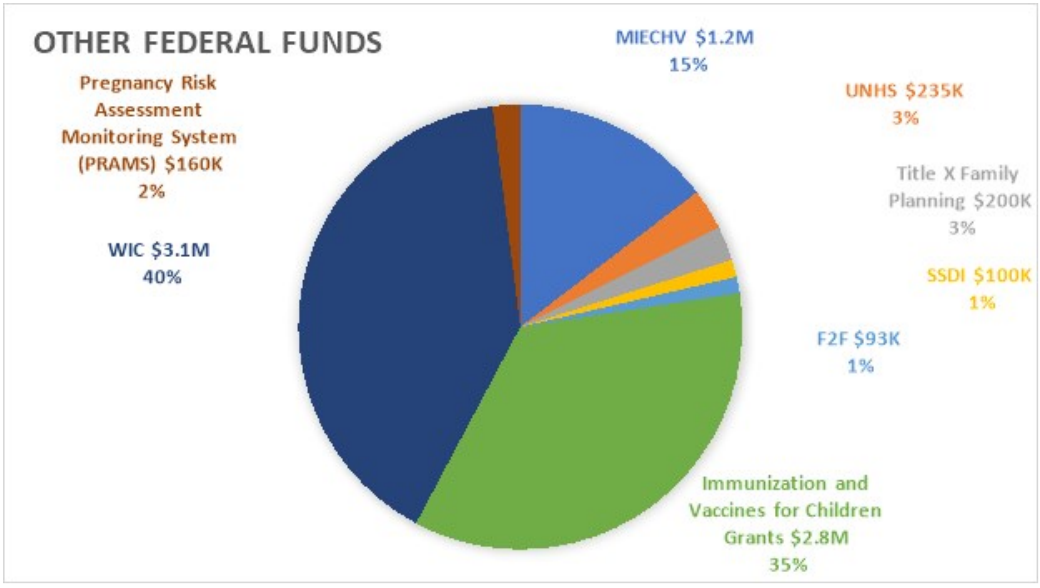
Legislative Requirements Met:

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. As stated, the MCH Title V supports 50% of the MICAH Fiscal Specialist FTE. One of the major duties and responsibilities of this FTE is to continuously ensure that the funds are being budgeted and expended per the minimum required 30-30-10 percentage. The Fiscal Specialist provides the MICAH Administrator a monthly fund status report that consist of current funds available, funds encumbered, funds expended and the legislative required 30-30-10 percentage report. The Fiscal Year 2023 Title V Block Grant estimated budget proposal of $466,540 consist of the following types of individuals served: Pregnant Women and Infants less than 1 year of age was budgeted at $106,743 which is at 23% of the total federal award. Preventive and Primary Care for Children was budgeted at $144,274 which is at 30.9% 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 $149,519 which is 32% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Administrative costs was budgeted at $42,004 which is 9.1% of the total direct costs of the federal grant award. A total of $24,000 was budgeted for All Other Costs such as dues and subscriptions, license and fees, repairs and maintenance, communication services, office space rental, utilities and cleaning services. The chart below provides a budget overview of the required federal allocation for the FY 23 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 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), Immunization and Vaccines for Children Grants, Women, Infants and Children (WIC) & Pregnancy Risk Assessment Monitoring System (PRAMS)].



The Other Federal Funds under the control of the MICAH Administrator is responsible for the administration of the Title V program budgeted for the estimated amount of $7,930,007.

Total State Match:

The MCH match is budgeted at $479,204 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 $945,744. 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 Population Health Programs 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 Population Health Services (PHS) unit into the Maternal, Infant, Child and Adolescent Health (MICAH) section, with WIC and Immunization services integrated within the unit. As part of the re-organization, the PHS section had intended to update its vision and mission statements, organizational charts, and update its strategic plan to align with the re-organization. However, these activities were delayed due to impacts from the COVID-19 pandemic and is intended to be completed in 2022.

The CHCC is the only health department in the CNMI and provides all health department services, including direct, enabling and infrastructure building to all islands within the territory.
The CHCC Population Health Services unit is comprised of 3 sections:

- Maternal, Infant, Child & Adolescent Health (MICAH) Programs
- Non-Communicable Disease Programs
- HIV/STD & TB Prevention & Control Programs

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

- MCH Program
- Family Planning
- Children with Special Health Care Needs (CSHCN)
- Home Visiting
- Immunization & Vaccines for Children
- WIC
- Pregnancy Risk Assessment Monitoring System (PRAMS)

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. A total of 94 employees make up the Population Health Services (PHS) section in which 64 are stationed within 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 is funded by sources other than Title V, all contribute to the Title V mission and MCH priorities. For example, a substantial number of MICAH staff work within the Healthy Outcomes for Maternal and Early Childhood Visiting Program, carrying out the implementation of the CNMI HOME visiting work plan. In 2021, the MICAH went through another reorganization with Immunization and WIC programs integrated within the unit.

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 amount 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, there still remains the fact that 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 Acting MICAH Administrator and the Population Health Services Director are engaged in the planning and development to restructure and reorganize current staffing. Gaps identified in the current MICAH staffing structure will be 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 will be driven by community priorities as opposed to individual grant requirements.

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 this specific 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 as a challenge for recruiting medical providers and

turnover is high.

Staffing for the population health programs, including the Title V MCH Program, is largely made up of a local workforce. The MICAH Administrator, Fiscal Specialist, 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 HRSA National Health Service Corps.

Training

Staff within PHS have varied professional experienced and 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 PHS 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 Bureau'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 of our 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 population 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, MICAH programs 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

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. During the COVID-19 Pandemic, programs modified activities in order to continue providing services to family's needs. Family advocacy and empowerment was promoted through informative learning sessions, identification of various parent leaders, leadership training, creating support groups such as peer matching and providing opportunities to attend in national conferences virtually. Throughout the years, family involvement has increased. Now, families are more willing to participate in conducting surveys, attending partnership meetings, featuring in programmatic posters as family leaders and promoting programs through community health outreach events.

Moreover, for materials development, programs seek input from families who actively participate in MCH programs on items such as program brochures. Program informational materials, including those specific for the adolescent population, are reviewed by the Information & Education (I&E) committee and approved by them prior to printing and distribution to the community as a mechanism for ensuring that print materials are culturally and linguistically appropriate. The I&E committee is made up of community members of varying ethnic backgrounds, age groups, and segments of the community representatives of the CNMI population.

Strategies used to engage families in MCH activities in FY2021 include:

- The hiring of a Family Support Specialist, a parent of a child with special healthcare needs as a lead and main contributor to family engagement work.
- Providing stipends to parent leaders who participate in family engagement activities, provide peer support, translation services, and other related activities
- Providing trainings and virtual learning sessions to families
- Offering flexibility in meeting hours to meet family availability (evening or weekends)

Related advisory committees that MICAH programs are involved in which include family partners as members include the: Interagency Coordinating Council (ICC). Early Hearing Detection & Intervention (EHDI) Advisory group, CSHCN stakeholder group, H.O.M.E. Visiting Community Advisory Board, Governor's Council on Developmental Disabilities, 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. Through funding support from the CDC Foundation and the CHCC Epidemiology and Laboratory Capacity (ELC) Program, CHCC was able to recruit an Epidemiologist in August 2020 after more than a year of the position being vacant. Epidemiologist Emily Haanschoten came to the CNMI CHCC with epidemiologic skills and knowledge in oral health and WIC program as an epidemiologist for maternal and child health at the Montana Department of Health and Human Services. At CHCC, Emily was responsible for planning, developing, implementing and evaluating a wide range of investigative and analytical activities; conducting routine and advanced-level epidemiological work comprising surveillance, data collection and analysis, identifies trends, outbreaks of diseases or other adverse health events. She focused on optimizing data management and analysis through automated processes and efficient coding. Ms. Haanschoeten relocated to the US mainland shortly after the start of FY2022. The vacant epidemiologist position was filled with Ms. Jennifer Dudek who was recruited in FY2022 and transitioned into leading on-going projects along with new ones.
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.

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.

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: Jose (Ping) Santos. The IIS Coordinator position is supported through federal funding form the Centers for Disease Control and Prevention (CDC). Jose Santos completed college coursework in Computer Science and Technology from Stevens-Henager College and Boise State University in Boise, Idaho. He has worked for the past 8 years in Public Health, specifically focused on public health data systems and was formerly the EHDI Data Tracking and Surveillance and MCHB Systems Administrator. 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. Mr. Santos 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.

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).

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

The Commonwealth of the Northern Mariana Islands (CNMI) Maternal and Child Health (MCH) State Systems Development Initiative (SSDI) Project continue to expand the data capacity for the CNMI Title V MCH Block Grant program. The SSDI Project continues to lead data collection and analysis efforts for MCH health indicators to include all National Outcomes Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs) and Evidence-based or Informed Strategy Measures (ESMs).

COVID-19 Pandemic

As part of the ongoing effort to mitigate the worldwide pandemic of COVID-19, the SSDI, intermittently since January 2020 and throughout 2021, was tasked to assist the Commonwealth Healthcare Corporation's (CHCC) Medical Care and Treatment Site (MCATS), and Governor's COVID-19 Task Force with various COVID-19 related functions including COVID -19 airport surveillance; registration and screenings; mobilization of vaccination units; and other covid-19 related duties.

The SSDI continues to work closely with CHCC Webpragma, and Epidemiology Laboratory Capacity (ELC) program for gathering COVID-19, and Maternal, Infant and Child health data to inform the CNMI COVID-19 interactive dashboard and CHCC Population Health website respectively for government and public use.

Medsphere's EHR/RCM upgrade

CHCC's Health Information Technology (HIT) department in concert with Medsphere have completed plans for the implementation of CareVue electronic health record (EHR) and Revenue Cycle Management (RCM). The CareVue EHR/RCM go-live date was scheduled for October 31, 2021; the upgrade will provide CHCC clinicians with additional functionality including modern graphical user interfaces, automated clinical support, and a suite of pre-built interfaces to third-party applications and devices. With the addition of the RCM, CHCC is able to significantly improve its overall revenue and expenditures tracking system. The SSDI is working in collaboration with CHCC HIT, Centers for Disease Control and Prevention (CDC), and Medsphere to discuss options about onboarding of electronic case reporting (eCR).

Additionally, the SSDI Project Coordinator, along with other MICAH Program Coordinators, are involved in discussions for transitioning into a new EHR system that facilitates communication and collaboration between clinicians and Public Health Professionals which will improve patient care, reduce health disparities, and serve as a central data source for most MCH performance measures and indicators.

MCH Jurisdictional Survey

The National Opinion Research Center (NORC) at the University of Chicago, with its sub-contractor, Tebbutts Research, conducted both rounds of the Maternal and Child Health Jurisdictional survey. The first round (MCH-JS-19) and second round (MCH-JS-21) of Maternal and Child Health Jurisdictional survey was conducted in January/February 2020; and November/December 2021 respectively. The purpose of the MCH Jurisdictional Survey is to increase data capacity at the jurisdictional level for reporting on National Performance and Outcome Measures in the Title V MCH Block Grant application/annual reports; and to enhance tracking of tier 1 jurisdiction-specific priorities aimed at improving the health of MCH populations.

The design of both MCH Jurisdictional Survey were based on the National Survey of Children's Health (NSCH),

Behavioral Risk Factor Surveillance Systems (BRFSS), and the Youth Risk Behavior Surveillance System (YRBSS); the survey also intended to collect data on the physical and emotional health of mothers, with children under 18 years of age, including children with special health care needs.

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

As with MCH-JS-19, MCH-JS-21, 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, 270 household interviews were completed at various geographic locations, but because of the small population size, certain cases from respondents 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-21 survey is essential for meeting the federal reporting requirements and to demonstrate progress on National Performance and Outcome Measures (NPMs and NOMs), and 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 and MCH-JS – 21;

Table 1

Summary of Key Factors	MCH-JS-19	MCH-JS-21	Status
Enumerator Sites	Saipan	Saipan, Tinian and Rota	Improved
Targeted Sample Size	200	250	Improved
Total # of indicators (NOMs and NPMs)	33	33	Same
# of NOMs	14	14	Same
# of NPMs	19	19	Same
# and % of NOMs - Reliable estimates	7 or 50%	8 or 57%	Improved
# and % of NPMs - Reliable estimates	5 or 26%	10 or 53%	Improved
# 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%	Improved
# and % of NOMs 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%	Improved

2020 MCH Comprehensive 5-year Needs Assessment

The CNMI's MCH Comprehensive Five (5) - Year Needs Assessment provided MCH with valuable information that identify needs of the community and opportunity to assess resources and capacity for addressing those needs. The SSDI Project with Public Health staff members used the findings from the five-year needs assessment to develop strategic plans for collecting and analyzing quality data for informed decision making and implementing

evidence-based or informed strategy measures to improve health outcome of the people in the CNMI. Table 2 illustrates the priority needs by population domains as identified through the comprehensive 2020 five (5)-year needs assessment, strategies aimed for addressing priority needs including SPM/ESM, and definitions to measure progress/performance for meeting those needs.

Table 2

Priority Need	NPM/SPM	Objectives	Strategies	Activities	ESMs	DEFINITION
Women/Maternal Health						
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 medical visit in the past year	By 2025, increase the number of women who access preventive visits to 65%, an increase from baseline of 56%	Expand access: Outreach and/ or Increased clinic hours.	1. Utilize the CHCC mobile clinic to provide access primary care and preventive screenings for women. 2. Conduct community awareness activities to promote primary care and preventive screenings for women.	**ESM 1.1**: Percentage of women ages 18 through 44 who reported accessing preventive services at CHCC clinics during extended hours and/or outreach events	Measure: % Numerator: Number of women ages 18-44 years accessing preventive health services during CHCC clinics extended hours and/or outreach events Denominator: Number of women ages 18-44 years
Perinatal/Infant Health						
Education and support Breastfeeding	**NPM 4 - A)** Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	By 2025, increase of the percentage of infants **breastfed through 6 months** to 54%, an increase from the baseline of 45%.	Implement workplace breastfeeding policies/support.	Develop or strengthen prenatal clinic policies on breastfeeding education and counseling. Expand workplace breastfeeding support Conduct community awareness regarding the importance of breastfeeding for infant health Support breastfeeding supplies for families accessing hospital and clinic services	**ESM 4.1** - Percentage of infants who were breastfed at 6 months.	Measure: % Numerator: Number of infants who were breastfed throught 6 months. Denominator: Total number of infants
Prevention of adverse birth outcomes through Prenatal Care.	**SPM 1** -: Percent of live births to resident women with first trimester prenatal care.	By 2025, increase the number of pregnant women with first trimester prenatal Care to 65%, an increase from the baseline percentage of 55%.	Provide service navigation for pregnant women	Service coordination for prenatal patients (support to address access challenges, i.e. uninsured assistance, transportation vouchers, etc.) Expand partnerships with the WIC and Family Planning clinics to increase early prenatal care rates		Measure: % Numerator: Number of live births by resident women with first trimester prenatal care. Denominator: Total number of live births by resident women.
Child Health						
Obesity related issues including nutrition and physical activity	**NPM 8.1** - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	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%.	To partner with the Northern Marianas College (NMC) to increase the number of parents/caregivers or families who enroll in an evidence based nutrition program (EFNEP).	Increase the number of parents/caregivers enrolling in evidence based nutrition and physical activity curriculum/programs to build capacity among families to address nutrition and physical activity needs. Conduct community awareness and health promotion activities to promote physical activity for children ages 6 through 11 years.	**ESM 8.1.1** Percentage of referrals who report completing at least 75% of the EFNEP program curriculum.	Measure: % Numerator: Number of referrals who reported completing at least 75% of the EFNEP program curriculum. Denominator: Number of referrals to the EFNEP program

Table 2 Cont'd

Adolescent Health						
Priority Need	NPM/SPM	Objectives	Strategies	Activities	ESMs	DEFINITION
Coping skills and suicide prevention	NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	By 2025, increase the percentage of adolescents who access well visits to 55%, an increase from baseline of 42%.	Partner with the Public School System to increase the number of adolescents accessing adolescent health visits.	Work with pediatric providers to ensure that evidence based behavioral health screenings is included during teen wellness visits. Update partnership MOU to include well-visit reminders and referrals to MCH as a key partnership activity. Develop post-cards and other effective communications information to distribute to families of teens via school partners Conduct monthly assessment on the number of teens accessing well-visits at all CHCC sites (Children's Clinic, Family Planning, Mobile Clinic, Rota Health Center, and Tinian Health Center).	**ESM 10.1** Percentage of adolescents accessing preventive care through referrals from the Public School System (PSS)	Measure: % Numerator: Number adolescent who were referred by Public School System for prevent care visit Denominator: Number adolescent who access preventive care visit.
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.	By 2025, increase the number of adolescents ages 12 through 17 years with and without special healthcare needs who receive transition services to 64% and 51%, respectively, an increase from baseline percentages of 51% and 48%, respectively.	Provide education, presentations, and support to high school students and/or their parents in making transition into adult healthcare.	Work with youth serving partners to provide education and information to parents/caregivers and teens they serve regarding transition into adult healthcare Develop presentations utilizing information available via Got Transitions. Partner with the school system and Parent Teacher Association to develop a presentations schedule. Implement transition assessments for youth and parents of youth during presentation sessions. Conduct presentations	**ESM 12.1** - Percent of adolescents ages 12 through 17 years with and without special healthcare needs whose families reported increased knowledge about the importance of transition after presentations.	Measure: % Numerator: Number of adolescents with or without special health care needs, ages 12 through 17, whose families reported increased knowledge about the importance of transition after presentations. Denominator: Number of adolescents ages 12 through 17 years with or without special health care needs attending the presentation
Children with Special Health Care Needs (CSHCN)						
Priority Need	NPM/SPM	Objectives	Strategies	Activities	ESMs	DEFINITION
Helping parents/caregivers navigate the health care system for coordinated care	**NPM 11** - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	By 2025, increase the percentage of CSHCN who report having a medical home to 25%, an increase from a baseline percentage of 14%.	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	Coordinate CSHCN outreach events and collaborate with DNP on referral mechanisms.	**ESM 11.1** - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.	Measure: % 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.
Cross-Cutting/Systems Building						
Priority Need	NPM/SPM	Objectives	Strategies	Activities	ESMs	DEFINITION
Professionals have the knowledge and skills to address the needs of maternal and child health populations	**SPM 2** - Percentage of CHCC Population Health Services (PHS) staff and MCH Professionals who complete training on MCH priorities and related topics.	By 2025, at least 50% of CHCC PHS staff and MCH serving professionals will have completed training related to at least 75% of the CNMI MCH Title V population health domains.	Implement a learning management system to provide training and capture completion rates	Create a training plan, research topics/curriculums for each of MCH Title V population health domains; idenity objectives for each lesson topic, select appropriate instructional methods to administer training across CHCC PHS staff and MCH serving professionals.		Measure: % Numerator: Number of CHCC PHS staff and MCH serving professionals who complete training on MCH priorities and related topics. Denominator: Number of CHCC PHS staff and MCH serving professionals

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

Other MCH data capacity efforts include the following:

Pregnancy Risk Assessment Surveillance Monitoring System (PRAMS):
Commonwealth of the Northern Mariana Islands Pregnancy Risk Assessment Monitoring System (CNMI PRAMS) will be a joint research project between the Commonwealth Healthcare Corporation (CHCC) and the Centers for Disease Control and Prevention (CDC). The project involves the development and completion of a protocol and implementation of 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 CNMI PRAMS will strengthen capacity in the CNMI to produce high quality data not available from other sources relating to pregnancy and the first few months after birth and enable the monitoring of maternal and infant health indicators over time. The goal of CNMI PRAMS is to identify maternal risk behaviors that may affect both maternal and infant health. Findings from CNMI PRAMS will be used to enhance the understanding of maternal behaviors among the territory's diverse population and their relationship with adverse pregnancy outcomes. The CNMI CHCC will use PRAMS surveillance data for program planning and evaluation and influencing public health practice and policy for maternal and child health programs.

CareVue Electronic Health Record (EHR) System: The CHCC, CNMI Health Department, have transitioned to the CareVue EHR system; there are plans to implement 3 public health reporting interphases which Medsphere's CareVue EHR supports:

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

This upgrade is intended to improve the capturing and reporting of patient data and interoperability or linkages with other healthcare data systems. This project being spearheaded by the CHCC Health Information Technology (HIT) Department. The CHCC outpatient clinics serving women and children, emergency department, L&D, OB, Pediatrics, and other women and children serving hospital units will utilize this integrated health record system for capturing preventive, primary, and other patient care information.

Family Planning Annual Report (FPAR) 2.0: The CNMI Family Planning program completed computer hardware upgrades for Family Planning providers at the CHCC Women's Clinic, Rota Health Center, and Tinian Health Center. Additionally, through a partnership with the CHCC HIT, the program is working with CareVue to ensure that all FPAR 2.0 data elements required by the Office of Population Affairs are included in the development and deployment of the new CHCC EHR system.

Immunization System linkage to EHR- System Interoperability: Through a partnership with the HIT Department, the Immunization Program is working on upgrades to the CNMI Immunization Information System (IIS) called the WebIz, to enable linkages between the hospital and clinics EHR and the IIS. This upgrade will improve the capturing and reporting of vaccination data in the CNMI.

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; EHDI is currently in collaboration CHCC Heath and Vital Statistics for linking the EHDI systems with EVRS database.

CNMI MCH Data Sources

Data Source:	Periodicity	Electronic form	Link to vital records	Information Gathered
HVSO Birth	Quarterly	Yes		Birth Rates, preterm births, prenatal, Maternal morbidity and mortality, fetal and infant deaths, birth weights congenital anomaliies, birth outcome
HVSO Death	Annually	Yes	Yes	
Medicaid	Monthly	Yes	No	Number of Pregnant women and children enrolled
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	No	Number of infants who received newborn bloodspot screening
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	Never	No	Yes	Number of women enrolled in the PRAMS Program
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 Diagosis 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
Women's Health Survey - Access to Health care services	Every 2 years	Yes	No	NOM - 2, 3, 4, 5, 6, 8, 9.1, 9.2, 9.3, 9.4, 9.5, 10, 11, 14, 17.2, 19, 23, 24 NPM - 1, 2, 13.1, 14.1
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, 13.1, 13.2, 14.1, 14.2, 15

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). 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 health department 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 may provide 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. As the health department, 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 Population 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 action steps for strengthening MCH focused activities within the CHCC EDP and the EOP, including:
Strategy: Integrate MCH considerations into state/territory EPR Plan

Activities:

- During the next 12 months, the MCH Director and the Public Health Emergency Program (PHEP) directors will meet at least one time to discuss EPR needs related to maternal and infant health.
- An MCH staff member will annually update the list of local and state/territory MCH partners, stakeholders and/or social networks to ensure that the contact information is accurate.
- An MCH staff member will ensure that state/territory EPR guidance for sheltering and other mass care needs address maternal and infant populations and the specific needs such as supplies and instructions for infant feeding and safe sleep.
- Annually the MCH program updates its roster of which MCH staff members are trained to assume leadership or other positions during a response if the hazard has a disproportionate effect on women of reproductive age and/or infants.

Strategy: Develop a plan to gather epidemiologic/surveillance data on women of reproductive age and infants to guide action

Activities

- Two MCH or state/territory epidemiologists (or more) will estimate the number of pregnant women in a jurisdiction.
- During the next three years, the state/territory will assess emergency preparedness among postpartum women using the Pregnancy Risk Assessment Monitoring System (PRAMS) or a PRAMS-like survey.
- Within the next three years, the state/territory will assess emergency preparedness among MCH populations using selected disaster preparedness questions in the CNMI Hybrid Survey.
- At least one ALC team member assesses possible use of DRH Post-Disaster Health Indicators in emergency data collection tools for pregnant/postpartum/lactating women.

Title V Preparedness Efforts: The CNMI's Title V Director worked collaboratively with the PHHEPP Planner in the development of the CNMI's COVID-19 vaccination plan. 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 worked collaboratively to lead 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.

During 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.

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 in conducting annual equipment calibration as off-island vendors were not able to enter the CNMI to calibrate the equipment due to travel quarantine protocols. The program had to negotiate loaner equipment and work to send equipment to the state of Oregon to complete annual equipment calibration requirements.

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.

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.

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.

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 will be sampling 100% of all resident births in the territory and will begin sampling 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.

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) section. Preventive and primary care services for women and children are provided at the CHCC Women's Clinic, Children's Clinic – both are located at the hospital; and Rota and Tinian Health Centers- located on the islands of Tinian and Rota. 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 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, the MCH program works closely with community based partners on a variety of 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.
- Association for Maternal & Child Health Programs (AMCHP)
    - Emergency Preparedness & Response Action Learning Collaborative
        - The CNMI joined a multidisciplinary team, participated in peer to peer sharing, received information/guidance from national experts and individualized technical assistance, and completed an action plan for incorporating MCH into emergency preparedness and response efforts.
- Northern Marianas Housing Corporation (NMHC)
    - Through a partnership with the CNMI NMHC, the CHCC was able to procure a new state of the art mobile clinic. The mobile unit was built based on specifications requested by the CHCC and has arrived on Saipan on June 2022. The mobile clinic will be used as an extension of the CHCC primary

care clinics and will offer preventive visits and screenings, including oral health, to the various villages in the CNMI.

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

CNMI MCH Title V program staff also participate 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 that endeavors to enhance the lives of individuals with Disabilities and 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.

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 simply by filing 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 and provided the CNMI and FMAP rate of 83 percent. In October 2021, the CNMI FMAP rate reverted to 55 percent. However, the CNMI will continue to qualify for the temporary 6.2 percent point increase under section 6008 of the Families First Coronavirus Response Act

(FFCRA) through the end of the quarter in which the public health emergency ends.

The table below, with information provided by the Medicaid and CHIP Payment and Access Commission (MACPAC), illustrates a comparison of Medicaid funding allotments for Fiscal Years 2019-2022 (millions) for the US territories.

Territories	2019	2020		2021		2022[1]
		Without P.L. 116-94 and FFCRA	Current law	Without P.L. 116-94 and FFCRA[1]	Current law	
American Samoa	$12.2	$12.4	$86.3	$12.7	$85.6	$13.0
CNMI	6.7	6.9	63.1	7.1	62.3	7.2
Guam	18.0	18.4	130.9	18.8	129.7	19.2
Puerto Rico	366.7	375.1	2,716.2	383.7	2,809.1	392.5
USVI	18.3	18.8	128.7	19.2	127.9	19.6

Source: Medicaid and CHIP Payment and Access Commission

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.

Towards the end of Fiscal Year 2021, H.R. 5376 – Build Back Better Act was introduced which includes permanent funding for the CNMI and other territories. Should H.R. 5376 be signed into law, the CNMI Medicaid Program is expecting over $70 million federal dollars annually with only 17% of the local matching requirement[1].

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.

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 in the CNMI through FY 2020.

CNMI Medicaid Program Enrollment by month - FY2020

	Fiscal 2019	Fiscal Year 2020											
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Medicaid / CHIP	14,189	787	846	880	1,355	1,050	648	1,147	1,250	1,883	1,598	1,266	1,129
Presumptive Eligibility	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	732	4,478	2,423	976
Total Enrollment	14,189	14,976	15,822	16,702	18,057	19,107	19,755	20,902	22,152	24,767	30,843	34,532	36,637

Source: CNMI State Medicaid Agency

In FY 2019, the CNMI had a little over 14,000 individuals enrolled in the Medicaid program. By the end of FY 2020, the CNMI had a total of 36,637 Medicaid program enrollees, out of a total estimated population size of 47,329[2]. Medicaid Presumptive Eligibility had been extended into FY2022 and will continue until the Public Health Emergency is ended.

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 a medical referral review board, provides coverage for off-island medical care to those enrolled.

[1] Commonwealth Medicaid Agency. (2021). 2021 Citizen-Centric Report. Retrieved on July 27, 2022 from CMA-FY-2021-CCR.pdf (opacnmi.com)
[2] US Census Bureau. (2021). 2020 Island Areas Censuses: Commonwealth of the Northern Mariana Islands. Retrieved on July 27, 2022 from https://www.census.gov/data/tables/2020/dec/2020-commonwealth-northern-mariana-islands.html

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

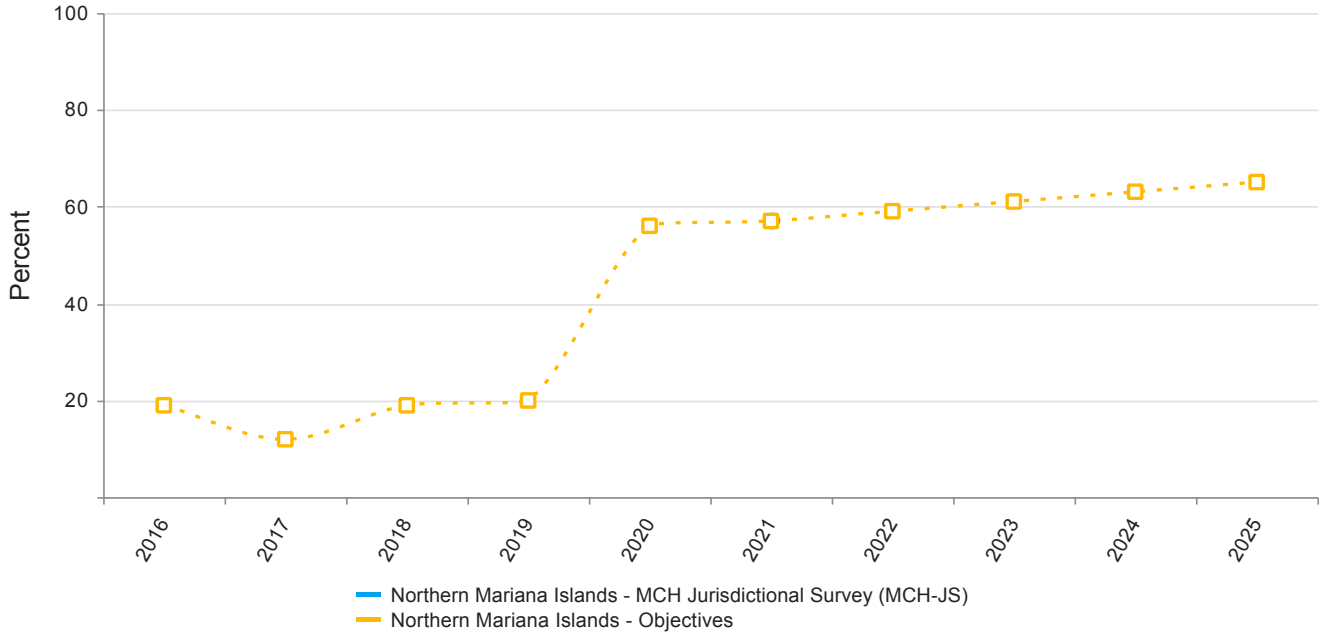
State Action Plan Introduction

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 FY2023 as well as a report on activities that were completed in the reporting year, FY2021. 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 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS)			
	2019	**2020**	**2021**
Annual Objective		56	57
Annual Indicator	55.5	55.5	57.1
Numerator	6,544	6,544	7,415
Denominator	11,784	11,784	12,993
Data Source	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	12	19	20	56	57
Annual Indicator	18.1	18.7	19.7	41.9	65.7
Numerator	1,425	1,437	1,516	3,238	5,071
Denominator	7,863	7,690	7,689	7,721	7,717
Data Source	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CHCC Preventive Visits and US international census	CHCC EHR/RPMS Preventive visits
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	59.0	61.0	63.0	65.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at CHCC clinics during extended hours and/or outreach events

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			5
Annual Indicator			0
Numerator			0
Denominator			7,717
Data Source			CHCC Clinics and Outreach events query records
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	49.0	50.0	51.0	52.0

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 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
By 2025, increase the number of women who access preventive visits to 65%, an increase from the baseline of 56%	
Strategies	
Expand access: Outreach and/ or Increased clinic hours.	
ESMs	Status
ESM 1.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at CHCC clinics during extended hours and/or outreach events	Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

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

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

In FY2021, the MCH Services Coordinator was trained to process Medicaid Presumptive Eligibility (PE) applications under the CHCC financial assistance program and worked closely with the revenue cycle office in processing application for Medicaid for women and children during the COVID-19 public health emergency (PHE). The CHCC was designated as a qualified entity to conduct Presumptive Eligibility determinations for Medicaid and the revenue cycle office was the CHCC unit responsible for overseeing this responsibility. Referral mechanisms were established across the various MICAH programs to connect uninsured women and children to the MCH Services Coordinator for Medicaid PE. Additionally, through partnership with the CNMI Women's Clinic department, an office for MCH services was established within the Women's Clinic to streamline patient referrals and enable tandem visits to minimize loss to follow up, efficiently address barriers to care and other risk factors patients may be identified with.

The COVID-19 pandemic continued to pose a challenge for MCH block grant activities and strategies identified in the MCH work plan. Nurses, providers, and Public Health staff continued to be heavily involved in response work and actively supporting testing, contact tracing, vaccinations, and risk communication efforts.

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	2020	2021
Percent	55.5	57.1
Numerator	6,544	7,415
Denominator	11,784	12,993

Source: MCH Jurisdictional Survey

Data to inform NPM 1 is gathered through the MCH Jurisdictional Survey conducted in the CNMI. In 2020, 55.5 percent of women ages 18 through 44 years reported an annual visit and in 2021 that percentage was 57.1, a slight increase.

Strategy: *Expand preventive healthcare: Increase clinic hours*

Evidence Based Strategy Measure 1.2: Percentage of women who report accessing preventive health services at CHCC.

Efforts to expand clinic hours were challenged by our health department response to the pandemic. Public health workers, nurses, and medical providers were leveraged across the health system to address response efforts. Public health workers and nurses were deployed to assist with testing and vaccination efforts. Efforts were maximized to ensure that normal clinic hours were not adversely impacted by COVID.

Additionally, the manufacturing of the CHCC mobile clinic unit was delayed over a year due to challenges caused to the manufacturer by the pandemic. Utilizing the mobile clinic unit was a strategy intended to expand hours and accessibility to women's preventive healthcare in the CNMI.

Despite these challenges, the CNMI did see an increase in the number and percentage of women accessing preventive health services. Due to expanded Medicaid eligibility made possible by the Presumptive Eligibility (PE)

more community members received financial assistance via Medicaid for healthcare. Additionally, the PE coverage was accepted at all private clinics, in addition to the CHCC clinics. These developments addressed financial concerns surrounding healthcare as well as increased access points for preventive services. Additionally, in 2021, there was an increase in Family Planning patients and number of Pap tests conducted in the CNMI as indicated in the tables below.

Percentage of females Served by the CNMI Family Planning Program, 2016 - 2021

Year	2016	2017	2018	2019	2020	2021
% Served	11.7	11.6	14.6	16.3	15.1	16.1
Numerator	953	921	1127	1262	1164	1241
Denominator	8114	7895	7732	7742	7721	7717

Data Source: CNMI Family Planning Annual Report

Number of Pap Tests Conducted in the CNMI, 2016 - 2021

CNMI PAP Data	2016	2017	2018	2019	2020	2021
Number of Tests	1,669	1,425	1,437	1,516	1,895	2,682

Data Source: DLS Hawaii

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

Social media and CNMI Women's Health Month activities were the main activities for conducting community awareness on women's health in 2021. CNMI Women's Health Month is celebrated during the month of May each year. In 2021, there were a total of 27 social media posts during CNMI Women's Health Month with a total "reach" of 24,931, 316 "likes" and 103 content "shares". Additionally, a live social media "Doc Talk" event was coordinated in partnership with OB/GYN and Family Planning medical director, Dr. Maria Hy where she provided information and answered general questions regarding women's health. A live radio talk show was also conducted in partnership with a local radio station where prenatal care and available women's health services in the CNMI was highlighted.

Women/Maternal Health - Application Year

The CNMI MCH Title V priority for women/maternal health continues to focus on access to health services. The MCH program will work in partnership with clinical providers and other partners to ensure activities to address this priority are implemented on the islands of Saipan, Tinian, and Rota. Additionally, the newly acquired mobile clinic that arrived in the Summer of 2022 will be a critical component for strategies identified for expanding and increasing access to preventive healthcare for women within the territory. Partnerships with the CHCC outpatient clinics, Family Planning Program, and clinical providers will be leveraged to support activities under this health domain.

Priority 1, Ability to find and see a doctor when needed (access to health services) is associated with NPM 1, Percent of women, ages 18 through 44, with a preventive medical visit in the past year. The objective is to increase the percentage of women who access preventive visits to 65% from the baseline of 56%. The CNMI will utilize the strategy of increasing clinic hours and services to improve the percentage of women in the CNMI accessing preventive health services.

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%, an increase from the baseline of 56%

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

The MICAH programs will work with the CHCC outpatient clinics and Family Planning programs to conduct activities to increase the number of community mobile clinics, by utilizing the newly acquired Mobile Clinic. Expanded service hours will be prioritized providing clinic on evening and/or weekend hours.

Additionally, MCH will partner with Family Planning to increase women's preventive health services by offering Saturday Family Planning clinics at the Immunization clinic.

For FY 2023, October 2022 thru September 2023, the following activities provide an outline of the strategy that will be implemented for improving access to preventive health services for women:

Mobile Clinic

- Develop and finalize a schedule for women's health services to be offered via the mobile clinic. Mobile clinic schedule will include expanded hours' availability (evening or weekends) and will identify village settings for outreach services.
- Conduct community awareness to inform the community regarding mobile clinic outreach schedules by publishing social media advertisements and providing flyers to target populations, such as food stamp and WIC recipients, a month ahead of the clinic schedule.
- Conduct monthly monitoring and assessment of outreach activity to include: number of patients seen, type of preventive services provided, etc.
- Integrate screening for social determinants of health and implement referrals for patients who identify a need for connecting with other available community services (i.e. Medicaid, education programs, housing programs, etc.)

Weekend Family Planning Clinics

- Partner with the Immunization Program and Family Planning to finalize a schedule, secure providers and supplies to offer Saturday Family Planning clinics.
- Conduct community awareness to inform the community regarding expanded Family Planning service hours and site by publishing social media advertisements and providing flyers to target populations, such as food stamp and WIC recipients, and teens a month ahead of the clinic schedule.
- Conduct monthly monitoring and assessment of expanded Family Planning hours to include: number of patients seen, type of services sought, etc.
- Integrate screening for social determinants of health and implement referrals for patients who access services who identify a need for connecting with other available community services (i.e. Medicaid, education programs, housing programs, etc.)

There is moderate evidence that supports that the strategy of increasing or extending clinic hours is an effective intervention for improving women preventive healthcare access[1].

This strategy will be measured by an Evidence Based Strategy Measure (ESM) developed to monitor the impact of the strategy on the women population targeted:

ESM 1.1: Percentage of women accessing preventive health services at CHCC Clinics.

Data to inform this ESM will be gathered through query of the CHCC Electronic Health Records (EHR). Both the mobile clinic outreach and Family Planning clinics will utilize the EHR for documenting patient visits and therefore can be queried to determine number of patients and types of services accessed on a monthly basis.

Strategy: 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. The MCH Program will work to develop communications and advertising materials to effectively inform the community regarding available services, service sites, and hours. Additionally, heath communication materials will focus on improving awareness and knowledge within the CNMI population regarding the importance of women's preventive healthcare. MICAH programs provide will connect with external partners: private clinics, private insurances and different faith-based organizations to disseminate information on services and health communication materials. Social media, radio and newspapers will also be leveraged for publishing information and for reaching a wide segment of the CNMI population.

For FY 2023, October 2022 thru September 2023, the following activities provide an outline of the strategy that will be implemented for community awareness on women's health services:

- Develop slide presentations, radio scripts, social media content, posters, and brochures/flyers to disseminate in the community.
- Conduct at least 6 presentations to community agencies regarding available women's health services and expanded service availability via the mobile and Saturday clinics.
- Develop a survey to utilize at mobile clinic events and at Saturday Family Planning clinics to evaluate communications materials.
- Conduct monthly assessment of social media advertisements identifying the number of individuals reached.

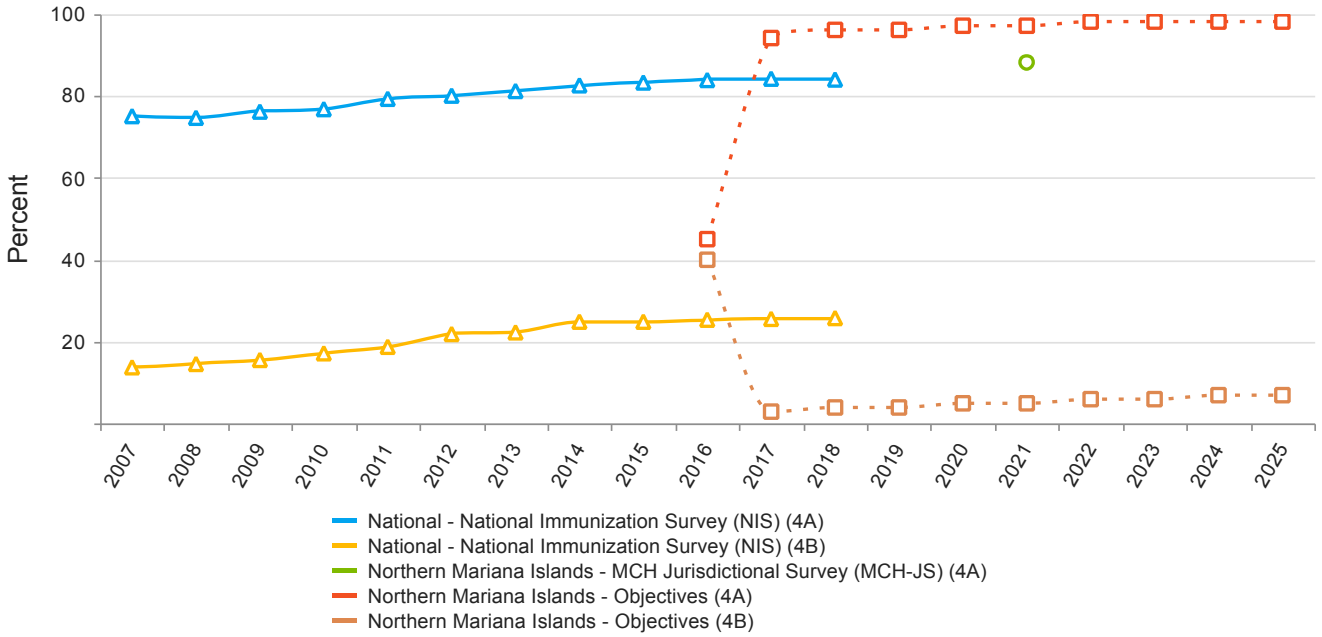
[1] Women's and Children's Health Policy Center John Hopkins University. (2017). Strengthen the Evidence Base for Maternal and Child

Health Programs NPM 1: Well Woman Visit. Retried on July 29, 2022 from https://www.mchevidence.org/documents/reviews/npm_1_well_woman_visit_evidence_review_brief_june_2017.pdf

Perinatal/Infant Health

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

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

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	94	96	96	97	97
Annual Indicator	94.7	95.8	96.5	93.3	93.7
Numerator	1,145	1,209	877	610	539
Denominator	1,209	1,262	909	654	575
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	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	98.0	98.0	98.0	98.0

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

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

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	3	4	4	5	5
Annual Indicator	2.5	2.5	1.1	0.4	0
Numerator	13	12	5	2	0
Denominator	518	486	470	544	419
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.0	6.0	7.0	7.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percentage of infants who were breastfed at 6 months.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			10
Annual Indicator			57.1
Numerator			238
Denominator			417
Data Source			WIC Program
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	57.4	57.6	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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	45	47	49	51	53
Annual Indicator	45.8	47.5	47.9	55	67
Numerator	297	323	334	347	381
Denominator	648	680	697	631	569
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	70.0	72.0	74.0	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 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
By 2025, increase of the percentage of infants breastfed through 6 months to 54%, an increase from the baseline of 45%.	
Strategies	
Implement workplace breastfeeding policies/support	
ESMs	**Status**
ESM 4.1 - Percentage of infants who were breastfed at 6 months.	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

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

Priority Need

Prevention of adverse birth outcomes through Prenatal Care.

SPM

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

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 is based on activities during FY 2021 (October 01, 2020 through September 30, 2021). 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.

Priority: Education and Support for Breastfeeding

NPM 4A: Percent of infants ever breastfed.

Breastfeeding	2016	2017	2018	2019	2020	2021
Percent of Infants	95.5	94.7	95.8	96.5	93.3	93.7
Numerator	1,162	1,145	1,209	877	610	539
Denominator	1,217	1,209	1,262	909	654	575

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 2021, 93.7 percent of live births were breastfed. The breastfeeding rate is maintained from the year prior.

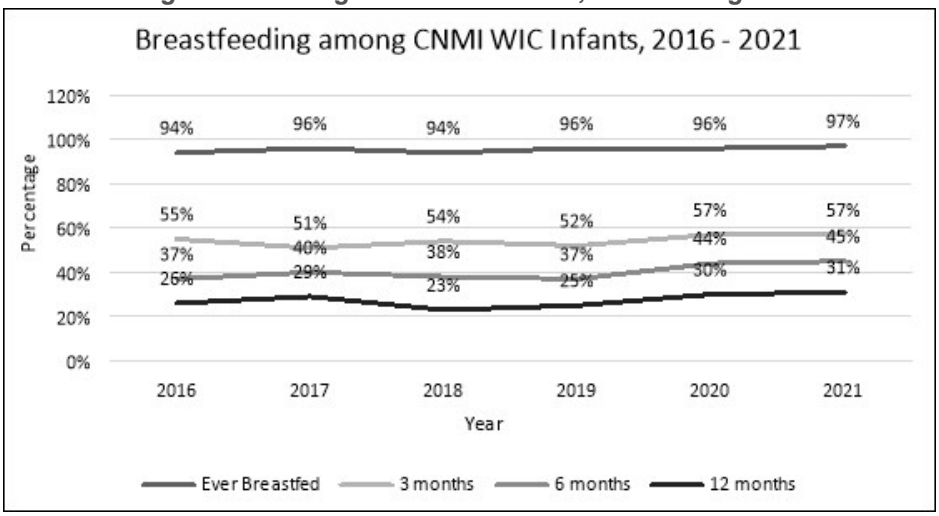
NPM 4B: Percent of infants breastfed exclusively through 6 months.

Exclusive Breastfeeding	2016	2017	2018	2019	2020	2021
Percent of Infants	1.7	2.5	2.5	1.1	.4	0
Numerator	9	13	12	5	2	0
Denominator	535	518	486	470	544	419

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 2021, there were no infants who met the criteria for breastfeeding exclusively through 6 months of age.

Breastfeeding Rates among CNMI WIC infants, 2016 through 2021



Source: CNMI WIC Program

While breastfeeding initiation rates in the CNMI of 93.7 percent is higher than US national rate of 84.1 percent[i], its 6 months breastfeeding rate (45 percent) trails behind the US average of 58.3 percent. A review of breastfeeding data from the CNMI WIC program from the past 5 years illustrates a steady increase in breastfeeding among infants. In 2021, 45 percent of WIC infants were breastfed through 6 months, an increase from 37 percent in 2016. Similar increases are seen in other infant age categories identified in the graph above.

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, only a little over half are being breastfed by 3 months of age and by 6 months, 45 percent are breastfed.
Many factors contribute to success in continued breastfeeding and support to breastfeeding moms is critical.

Strategy: Develop or strengthen prenatal clinic policies on breastfeeding education and counseling.
In FY 2021, MCH funds were used to procure breastfeeding supplies 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. Additionally, CHCC registered dietician and certified lactation specialist (CLS) Kayla Lindquist provided lactation consultation and support to hospital patients encountering challenges with breastfeeding.

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 are supported by Title V funds.

The COVID-19 pandemic created significant challenges towards the strategy in this section that targeted prenatal clinic breastfeeding policies. A large percentage of the health department staff, including those in the MCH unit, were directed towards supporting pandemic response activities. Clinic staff, including medical and nursing leadership, focused on responding to COVID-19 cases and implementing COVID-19 vaccination across health system clinical sites.

Activities related to this strategy are carried into FY 2022. The MCH system will be at a better position to address this strategy with the downsizing of pandemic response work and transition out of COVID-19 response efforts.

Strategy: Implement workplace breastfeeding policies/support

Similar to the strategy aimed at strengthening breastfeeding policies, activities to address workplace policies and supports were impacted by the COVID-19 pandemic. Many government and private businesses had temporary closures, shortened hours, and some transitioned into virtual work due to COVID. In addition to the limited workforce capacity, due to temporary staff assignments to support response work, the disruption caused by the pandemic made it challenging to engage CNMI employers as part of this strategy. This strategy continues into FY 2022.

Priority: Prevention of adverse infant outcomes through Prenatal Care

SPM 2: Percent of deliveries to resident women receiving prenatal care beginning in the first trimester of pregnancy.

Prenatal Care	2016	2017	2018	2019	2020	2021
Percent of Pregnant Women	43.4	45.8	47.5	47.9	55	67
Numerator	319	297	323	334	347	382
Denominator	735	648	680	697	631	572

Data Source: CNMI HVSO

In 2021, 67 percent of non-tourist live births were to women who initiated prenatal care early, which is an 11-percentage point increase compared to the year prior (2020) and a 24-percentage point increase compared to 2016. Additionally, the CNMI preterm birth rate in 2021 was 8.9 percent and 8.2 percent of live births were identified as low birthweight. Approximately 75 percent of total CNMI live births in 2021 were covered by Medicaid and 77 percent were to mothers enrolled in WIC. Among total live births, 16 percent were to women with gestational diabetes and 3 percent were to women with pre-pregnancy diabetes. Four percent of total live births were to women who did not receive any prenatal care.

Strategy: Increase community awareness regarding the importance of early and adequate prenatal care.

In 2021, radio and social media outlets were utilized by MCH to promote awareness about the importance of early and adequate prenatal care. In May of 2021, as part of CNMI Women's Health Month, MCH Services Coordinator Antonio Yarobwemal and Public Health Educator, Keanna Villagomez Lin, participated in a live radio talk show that featured prenatal care. Both MCH Service Coordinator and Public Health Educator are trained group prenatal care facilitators and has worked closely with CHCC Women's Clinic provider in facilitating group prenatal care sessions prior to the pandemic.

Strategy: Increase access to prenatal care

In 2021, in partnership with CHCC Women's Clinic medical provider and Family Planning Medical Director, Dr. Maria Hy, the MCH program worked to enhance clinical care provided at the Women's Clinic by integrating service

coordination activities at the clinic site. MCH Services Coordinator, Antonio Yarobwemal, was transferred into the Women's Clinic to offer tandem office visits for patients who may be at risk for late or missed prenatal care visits or who may have healthcare access challenges (i.e uninsured, transportation challenges, etc). The MCH Services Coordinator provided assistance with expedited Medicaid application processing, Medicaid Presumptive Eligibility application processing, transportation vouchers, and referrals to programs such as WIC and Home Visiting for Women's and Children's Clinic patients. Follow-up with patients who missed appointments, laboratory testing, and other provider visits were also conducted by the MCH Service Coordinator. The MCH Service Coordinator also provides assistance to MCH patients who require off-island medical care, including expedited passport processing and Medicaid processing for urgent care cases. MCH funds were used to support the salary of the MCH Service Coordinator.

Additionally, MCH funds are used to purchase transportation vouchers that are issued to prenatal patients.

[i] Centers for Disease Control and Prevention. (2020). Breastfeeding Report Card.

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. Based on the MCH Title V guidance documents, the activities below reflect the time period of FY2023 (October 01, 2022 through September 30, 2023).

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 20201, 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 2022.

There are many factors that contribute to the CNMI's breastfeeding rates. A barrier cited by many working women involved a workplace that inhibits a woman's ability to express milk. 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.

Year 3 of the project will focus on assessing the number of workplaces that currently have breastfeeding policies and the types of supports offered to nursing women. The CNMI MCH Program will utilize the resources available in the Business Case for Breastfeeding toolkit available through the Office on Women's Health to gather feedback from working mothers on employee lactation support programs.

For FY 2023, October 2022 through September 2023, 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 3 months.

The program will be looking at infant breastfeeding at 3 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. Recent improvements have been made with 67% of live births in 2021 being to women who accessed early prenatal care, however, there is still room to improve. 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 2021, the percentage of first prenatal care had surpassed the 65% goal and therefore there was a need to adjust.

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 2023, October 2022 through September 2023, the following activities provide an outline of the strategy of providing service navigation for pregnant women in the CNMI:

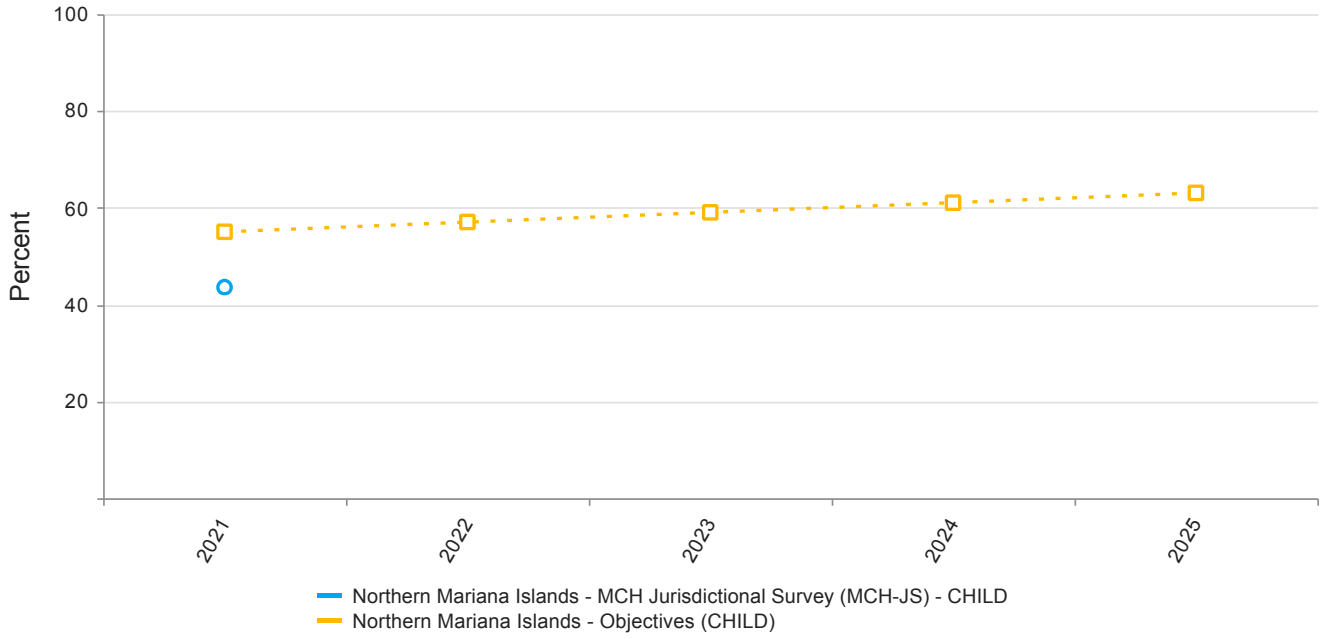
Service Navigation for Prenatal Women

- Partner with WIC to strengthen identify and refer women for service navigation
- Partner with Family Planning to promote free pregnancy testing to identify pregnant women early and connect with service navigation when needed
- Integrate screening for social determinants of health and implement referrals for pregnant women who identify a need for connecting with other available community services (i.e. NAP, education programs, housing programs, etc.)

Child Health

National Performance Measures

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD			
	2019	**2020**	**2021**
Annual Objective			55
Annual Indicator	52.7	52.7	43.5
Numerator	2,769	2,769	2,393
Denominator	5,253	5,253	5,498
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019	2021

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	57.0	59.0	61.0	63.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - 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
Annual Objective			10
Annual Indicator			0
Numerator			0
Denominator			142
Data Source			MCH referral log and EFNEP enrollment record
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Child Health - Entry 1	
Priority Need	
Obesity related issues including nutrition and physical activity	
NPM	
NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	
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	
To partner with the Northern Marianas College (NMC) to increase the number of parents/caregivers or families who enroll in an evidence based nutrition program (EFNEP).	
Increase community awareness on the importance physical activity for children.	
ESMs	**Status**
ESM 8.1.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.	Active
NOMs	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	

In FY2021, the MCH program continued to be impacted by the COVID-19 pandemic. Much of the health department staff including those in the MICAH unit were reassigned to take part in the operations in response to the pandemic. Key partners in child health were also focused on pandemic response. Many families were choosing to avoid public places and healthcare facilities for fear of being exposed to COVID-19 and in response to government mandates enforcing social distancing, masking, etc.

The priority need for child health is obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity. Strategies identified to address the need are to increase the number of children accessing well-child visits and to increase community awareness on physical activities for children.

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
Percent	52.7	43.5*
Numerator	6,544	7,415
Denominator	11,784	12,993

Data Source: 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. In 2020, based on the survey, 52.7 percent of children ages 6 through 11 years were physically active at least 60 minutes per day and in 2021 the percentage was 43.5.

Strategy: Increase the number of children accessing well-child visits.
Increasing the number of children accessing well-child visits was intended to increase the number of children receiving preventive screenings and anticipatory guidance on nutrition and physical activity from trusted medical professionals. Additionally, through informal interviews with pediatric providers, there was concern over the number of children not completing well-child visits. To address this, the MCH program partnered with the Immunization program to provide vaccination reminder and recall activities taking part in conducting phone call reminders to parents and caregivers for children who had missed vaccinations and those that had vaccinations coming up. Reminder calls were used as an opportunity to discuss the importance of well-child visits and staff provided assistance to families in scheduling visits where vaccinations could also be obtained.

In addition, the CNMI immunization “yellow card” was updated to include a well-child visit tracking section based on the American Academy of Pediatrics (AAP) recommended well-child schedule, to assist parents in keeping track and serve as reminder for parents regarding upcoming well-child visits. All babies born in the CNMI are provided the “yellow card” prior to discharge from birth.

Radio advertisements were also conducted in partnership with the Immunization program reminding families about the importance of well-child visits and that vaccinations are easily available and accessible to families during these visits. Posters regarding well-child visits were disseminated at Public School locations, partner agencies, and throughout the health system.

Strategy: Increase community awareness on physical activity for children.

The MCH program utilized 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 specifically on physical activity for children in the CNMI were developed to educate the community. The program was able to produce a physical activity education and awareness video that ran in the local movie theatre. Due to the pandemic, the only local movie theatre was forced to shut down resulting in a halt of the movie theater awareness project. Activities related to this strategy was carried into FY2022.

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 a 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 amongst 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% be 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.

For FY2023, CNMI MCH Title V's strategy for addressing priority need 4, obesity related issues including nutrition and physical activity will be to partner with the Northern Marianas College (NMC) to increase the number of parents/caregivers or families who enroll in an evidence based nutrition program.

Through a partnership with the Northern Marianas College Expanded Food and Nutrition Education Program (EFNEP), MCH will work to increase the number of parents/caregivers who are enrolling into the Eating Smart Being Active educational program offered by NMC EFNEP. The Eating Smart Being Active curriculum is an evidence based healthy eating active living curriculum that was originally developed in 2005. Lesson content includes physical activity, nutrition, healthy lifestyle choices, food preparation, food safety, and food resource management.

For FY 2023, October 2022 through September 2023, the following activities provide an outline of the strategy that will be implemented for increasing the number of families who enroll in the NMC EFNEP.

Increase enrollment in an evidence based nutrition and physical activity program

- Establish a partnership agreement with NMC to increase the number of families, parents or caregivers enrolling into the EFNEP program.
- Develop referral protocol to be implemented during well-child visits at CHCC outpatient clinics (Children's Clinic, Mobile Clinic, RHC, THC).
- Integrate screening for social determinants of health and implement referrals for those who identify a need for connecting with other available community services (i.e. NAP, education programs, housing programs, etc.)
- Conduct monthly assessment of referrals and enrollment into EFNEP
- Meet quarterly with NMC partners to assess progress or areas of opportunity.

ESM 8.1: Percentage of referrals who report completing at least 75% of the EFNEP program curriculum.

To measure the impact of the strategy on the priority area and objective, the MCH program will gather data on this measure through survey of individuals referred by MCH to EFNEP to identify the percentage of referrals who completed at least 75% of the program curriculum.

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 educate the community. Additionally, the program will partner with community agencies to disseminate the information materials developed to families that are served by the various partners.

For FY 2023, October 2022 through September 2023, 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

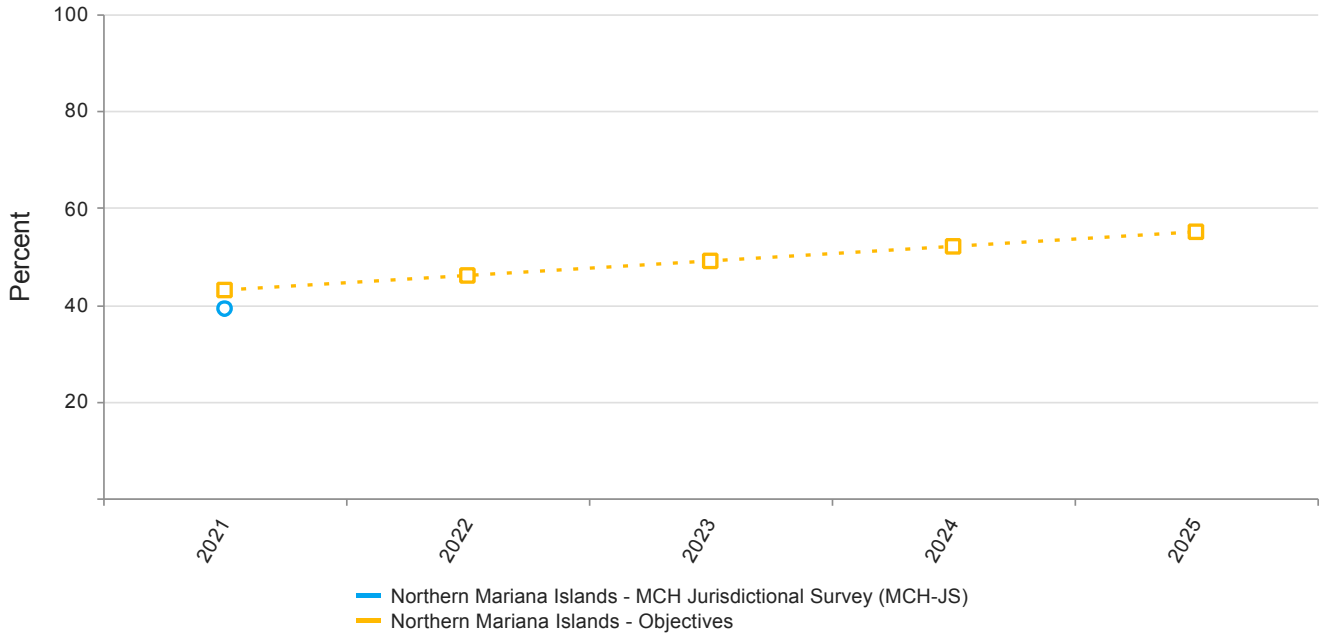
- Develop a communications plan for publishing social media, radio, commercials, and newspaper advertisements
- Revise and finalize social media advertisements, TV commercial content, radio scripts, and newspaper content layout.
- Monitor and evaluate reach and effectiveness of the advertisements and promotions activities.

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



Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS)			
	2019	**2020**	**2021**
Annual Objective			43
Annual Indicator	42.4	42.4	39.3
Numerator	2,593	2,593	2,156
Denominator	6,119	6,119	5,493
Data Source	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021

State Provided Data			
	2019	2020	2021
Annual Objective			43
Annual Indicator	19.1	6.8	22
Numerator	1,167	424	1,378
Denominator	6,094	6,215	6,256
Data Source	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	RPMS AND US INTERNATIONAL CENSUS ESTIMATES
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	46.0	49.0	52.0	55.0

Evidence-Based or –Informed Strategy Measures

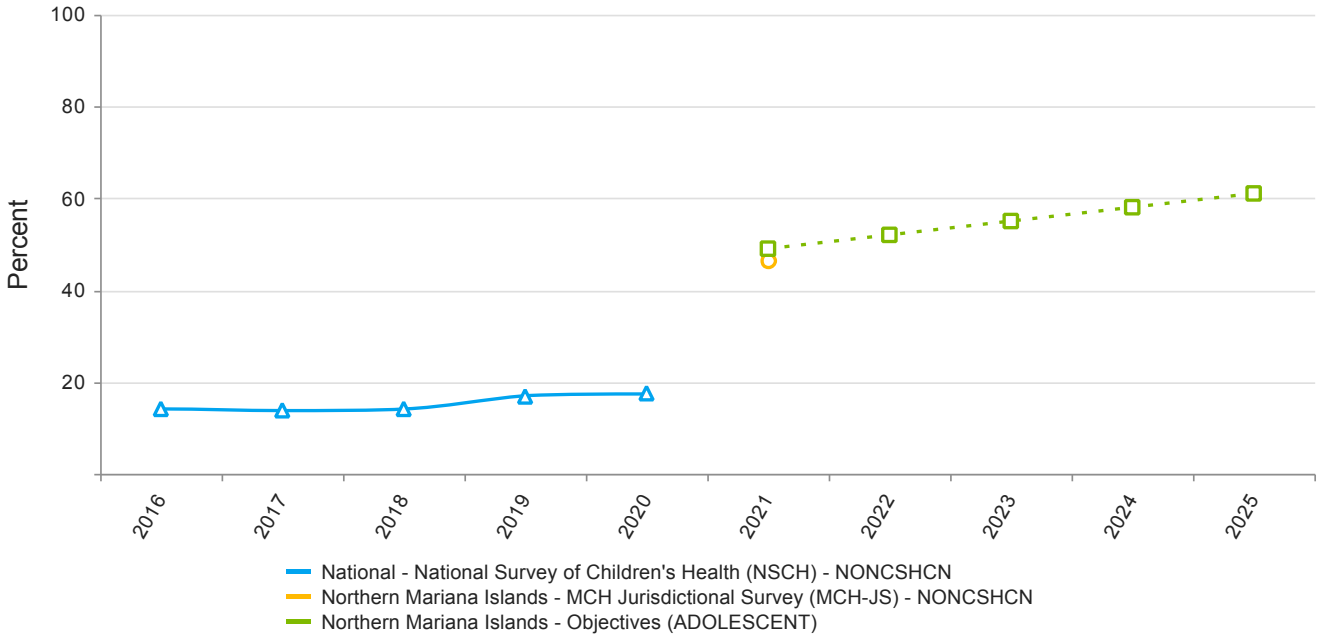
ESM 10.1 - Percentage of adolescents accessing preventive care through referrals from the Public School System (PSS)

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			10
Annual Indicator			0
Numerator			0
Denominator			1,378
Data Source			MCH service coordinator/EHR
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1.0	0.9	0.8	0.7

NPM 12 - 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
Indicators and Annual Objectives



NPM 12 - Adolescent Health - NONCSHCN

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS) - NONCSHCN			
	2019	**2020**	**2021**
Annual Objective			49
Annual Indicator	48.4	48.4	46.3
Numerator	2,788	2,788	2,306
Denominator	5,761	5,761	4,982
Data Source	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN
Data Source Year	2019	2019	2021

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	52.0	55.0	58.0	61.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of adolescents ages 12 through 17 years with and without special healthcare needs whose families reported increased knowledge about the importance of transition after presentations.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			10
Annual Indicator			0
Numerator			0
Denominator			5,493
Data Source			Pre-Post survey
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Adolescent Health - Entry 1	
Priority Need	
Coping skills and suicide prevention	
NPM	
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past 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 10.1 - Percentage of adolescents accessing preventive care through referrals from the Public School System (PSS)	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

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

NPM

NPM 12 - 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

Objectives

By 2025, increase the percentage of adolescents ages 12 through 17 years with and without special healthcare needs who receive transition services to 64% 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 12.1 - Percent of adolescents ages 12 through 17 years with and without special healthcare needs whose families reported increased knowledge about the importance of transition after presentations.	Active

NOMs

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

Activities identified in the FY2021 (October 01, 2020 – September 30, 2021) MCH Title V work plan for the adolescent health domain were impacted by the COVID-19 pandemic. Many of the outreach and presentations that were originally planned for were postponed due to temporary school closures and other disruptions caused by the pandemic. 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 to reach a large segment of the population. Much of the work in 2021 that was conducted with the school system was focused on COVID-19 testing and vaccination strategies as part of the overall CNMI's efforts for ensuring kids had access to safe learning environments and protected from severe disease when they transitioned back to face to face learning. Planning meetings were held and routine implementation assessment discussions were conducted, driven by data around COVID-19 infection and vaccination rates.

When vaccinations became available to teens in May of 2021, the MICAH leadership worked closely with Public School System leadership to collaborate on strategies to quickly increase vaccination coverage rates among youth. Gift certificates to local clothing shops and raffle prizes for electronic items, such as mobile phones, were utilized as incentives to motivate teens and their families. Another strategy that was adopted early in during the implementation of vaccinations for teens as young as 12 was ensuring that vaccine providers were assessing for and co-administering other routine vaccinations that may also be due for teens accessing COVID-19 vaccinations. This was critical for keeping coverage for vaccines like HPV and Tdap high among the adolescent population.

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
Percent	42.4	39.3
Numerator	2,593	2,156
Denominator	6,119	5,493

Data Source: CNMI MCH Jurisdictional Survey

Based on data gathered on teen well visits through the MCH Jurisdictional Survey conducted in the CNMI indicates a slight decrease in the percentage of teens accessing preventing health care in 2021 compared to the year prior.

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 were screened by medical professionals for potential behavioral concerns and connected to appropriate services that address coping skills and suicide prevention. The pandemic created challenges for MICAH programs staff to conduct originally planned face to face presentations at local middle and high schools. Schools throughout the CNMI experienced temporary school and periodic transition between face to face and virtual learning as schools responded to COVID-19 infections. MICAH programs staff worked creatively to engage individual school campuses and was able to conduct 5 classroom presentations and three virtual presentations where 164 middle and high school students participated. The presentations covered the importance of and the various components of the teen wellness visits. Additionally, confidential teen health services available via the Family Planning program were also

presented.

Additionally, in April of 2021, the MICAH programs partnered with the Public School System for the Youth Advisory Panel Conference, a 2-day event attended by approximately 200 youth leaders from middle and high schools from the islands of Saipan, Tinian, and Rota. The conference was for teens and facilitated by teens. MICAH Programs staff worked with a group of youth leaders from Kagman High School, providing training, a tour of the health department, and technical assistance in developing their slide presentation and prepare information for the event. MICAH programs staff were available during the conference to provide onsite technical assistance and other support or information that may be needed.

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.

Transition (Non-CSHCN)	2020	2021
Percent	48.4	46.3
Numerator	2,788	2,306
Denominator	5,761	4,982

Data Source: CNMI MCH Jurisdictional Survey

Based on data through the MCH Jurisdictional Survey conducted in the CNMI, 46.3 percent of adolescents without special healthcare needs, ages 12 through 17 years, received services necessary to make transitions into adult healthcare in 2021.

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

Similar 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. The partnership activities were impacted by a whole territory focus on the COVID-19 pandemic. The activities related to this strategy were carried into FY2022.

Adolescent Health - Application Year

Adolescent health continues to be a significant component in the collaboration between MICAH Programs and the local 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, thus leveraging partnerships with the CNMI school system an effective strategy for maximizing reach within the adolescent population. 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.

The need to promote positive coping mechanisms can be accomplished with yearly mental health screenings that can lead to suicide prevention and addressing bullying/bullies. Preventative health well visits for adolescents, which are fully covered under insurance and Medicaid, can promote overall physical health (immunizations, healthy eating, and oral health) as well as social emotional health (self-awareness, coping skills, managing stress). Primary care settings and pediatric providers are ideally suited not only as trusted resources for families and patients, but for playing a pivotal frontline role in identifying youth who are struggling and engaging them in supportive, effective care.

Priority need 5 is focused on adolescent coping skills and suicide prevention and linked to national performance measure 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 will visits to 55%, and 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 assess number of teens who are not up to date with annual teen visits and facilitate referral to MCH for access.

The program will focus on enhancing its partnership with the CNMI Public School System to identify adolescents who are due for wellness visits and connect them to the MCH Services Coordinator for an appointment. MCH Services will provide service navigation, appointment scheduling assistance, and offer transportation assistance as activities towards improving the percentage of teens completing well-visits. Additionally, the MICAH team will utilize information from the CNMI Immunization Registry, identifying teens enrolled in public and private schools and distributing reminders and information on the benefits of and how to access well-visits through school partners.

For FY 2023, October 2022 through September 2023, 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:

- Update partnership Memorandum of Understanding to include well-visit reminders and referrals to MCH as a key partnership activity.
- Develop post-cards and other effective communications information to distribute to families of teens via school partners
- Develop posters and distribute to all public and private middle and high school campuses in the CNMI.
- Conduct monthly assessment on the number of teens accessing well-visits at all CHCC sites (Children's Clinic, Family Planning, Mobile Clinic, Rota Health Center, and Tinian Health Center).
- Partner with pediatrics to ensure that evidence based behavioral screenings are included during preventive visits.

ESM 10.1: Percentage of adolescents identified and referred to MCH for well visits.

To measure the impact of the strategy on the priority area and objective, the MCH program will monitor and report on the number of teens referred to MCH for assistance with a well-visit appointment. Additionally, as the largest provider of healthcare services, teen visits to CHCC outpatient clinic sites will be monitored and reported on to identify if there is any increase in the number and percentage of teens who are completing well-visits.

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 aligned with national performance measure 12, percent of adolescent 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 64% 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.

Utilizing resources from Got Transition, presentations for high school students and parents of high school students will be conducted to prepare adolescents to be able to successfully transition into adult healthcare. This strategy is intended to enhance health literacy and understanding of the healthcare system in the CNMI among adolescents and aims to inform youth on available supports and services available through MICAH programs to enable their successful transition.

For FY 2023, October 2022 through September 2023, 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.
- Partner with the school system and Parent Teacher Association to develop a presentations schedule.

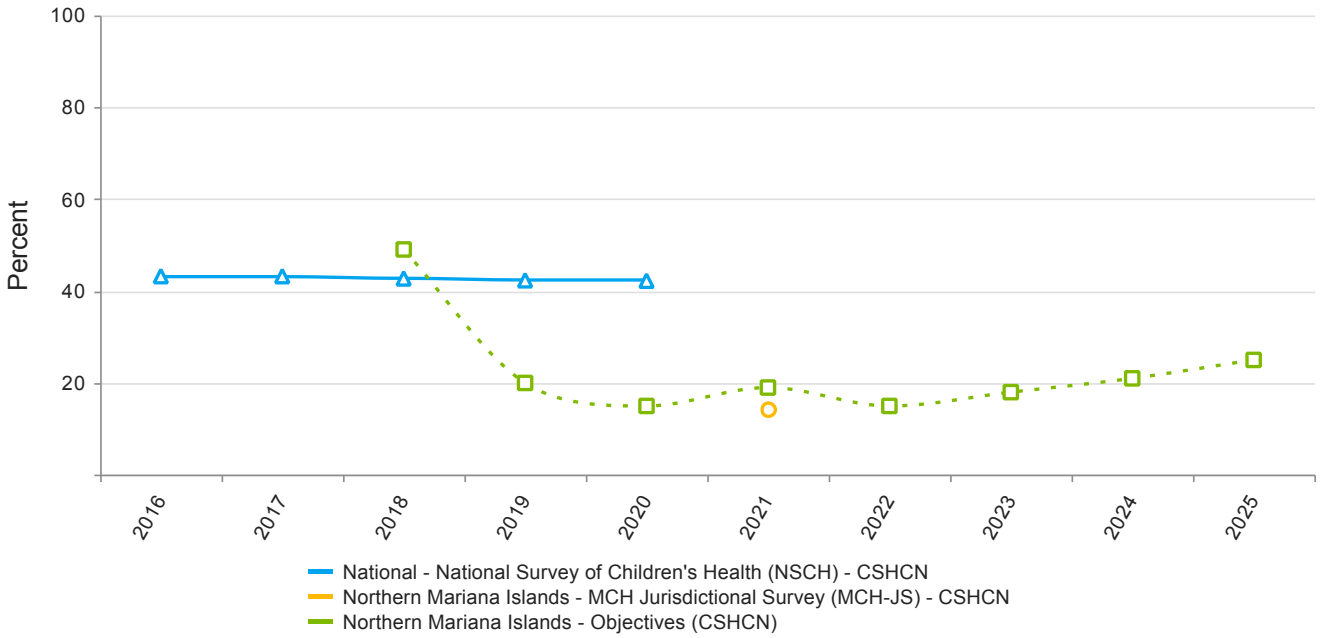
- Implement transition assessments for youth and parents of youth during presentation sessions.
- Conduct presentations
- Gather feedback/input on presentations to evaluate effective and identify areas of improvement.

Children with Special Health Care Needs

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

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

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective		49	20	15	19
Annual Indicator	46.8	19.6	19.6		
Numerator	37	54	54		
Denominator	79	276	276		
Data Source	CYSHCN Survey	CSHCN Survey	CSHCN Survey		
Data Source Year	2017	2018	2019		
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	18.0	21.0	25.0

Evidence-Based or –Informed Strategy Measures

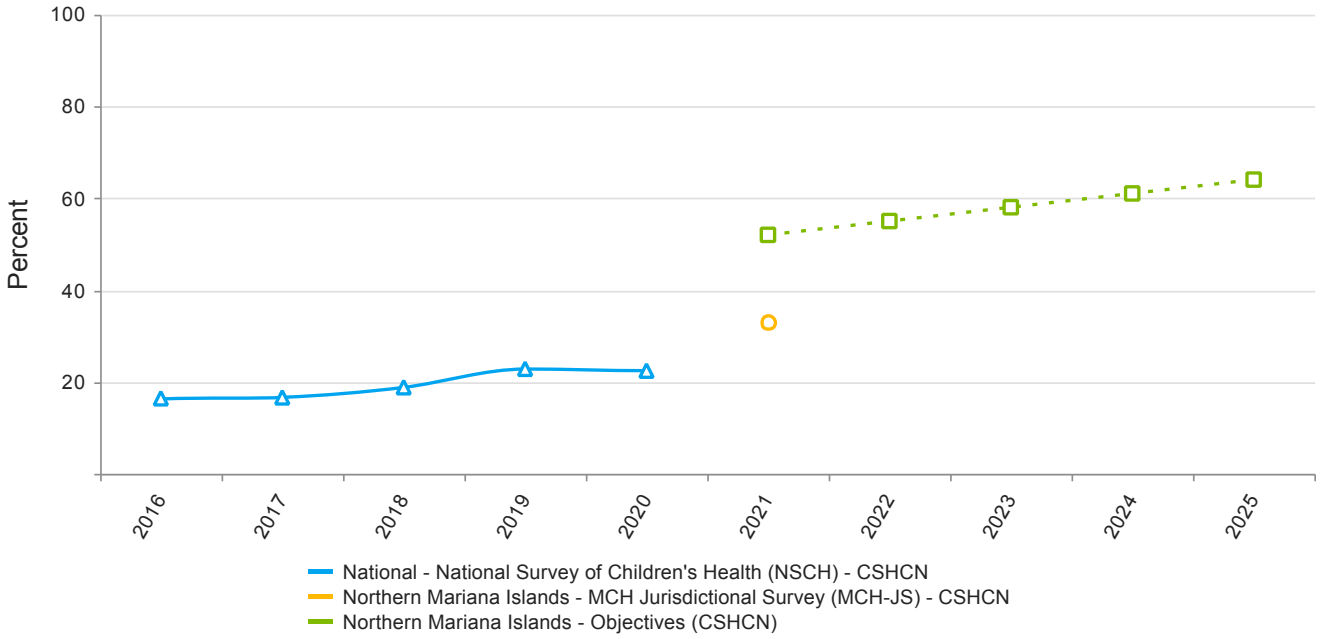
ESM 11.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			10
Annual Indicator			81
Numerator			51
Denominator			63
Data Source			F2F Medical Home Survey
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	20.0	30.0	40.0	50.0

NPM 12 - 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
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN			
	2019	**2020**	**2021**
Annual Objective			52
Annual Indicator	51.0	51.0	32.8
Numerator	183	183	167
Denominator	358	358	511
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	55.0	58.0	61.0	64.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of adolescents ages 12 through 17 years with and without special healthcare needs whose families reported increased knowledge about the importance of transition after presentations.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			10
Annual Indicator			0
Numerator			0
Denominator			5,493
Data Source			Pre-Post survey
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Helping parents/caregivers navigate the health care system for coordinated care	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
By 2025, increase the percentage of CSHCN who report having a medical home to 25%, an increase from a baseline percentage of 14%.	
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 11.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

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

Priority Need

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

NPM

NPM 12 - 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

Objectives

By 2025, increase the percentage of adolescents ages 12 through 17 years with and without special healthcare needs who receive transition services to 64% 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 12.1 - Percent of adolescents ages 12 through 17 years with and without special healthcare needs whose families reported increased knowledge about the importance of transition after presentations.	Active

NOMs

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

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 2021 (October 01, 2020 through September 30, 2021). 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.

Despite the program challenges caused by the COVID-19 pandemic, many of the programmatic activities that were significant aspects of the CSHCN program remain uninterrupted. Screenings and early identification activities were ongoing, service coordination for infants enrolled in EI continued, and all scheduled Shriner's outreach clinics were conducted. Training for parents/caregivers of CSHCN and professionals were conducted virtually throughout the reporting year. Support groups for families with children who have been diagnosed with down-syndrome and autism were able to transition from a virtual meeting format back to a face to face setting in 2021.

Through Title V block grant funds, the program supports two full time Service Coordinators that provide service coordination for families of infants and toddlers who are enrolled in Early Intervention (EI) Services. The MICAH unit also works with the EHDI Program Coordinator who oversees CHCC population health efforts on newborn hearing screening and family support for children identified as deaf or hard of hearing, those diagnosed with a condition through metabolic screening, and families who are seen through the Shriner's outreach clinic.

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

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

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

The Family to Family (F2F) Health Information Center, under the MICAH unit leads MCH activities focused on outreach and peer support to families of children and youth with special healthcare needs. Families that are identified through screening programs, the hospital NICU, Pediatrics department, and partner agencies such as the Public School System refer families to the Family to Family (F2F) Health Information Center. Additionally, the F2F Support Specialist conducts outreach and organizes parent-led CSHCN focused community events such as CNMI Autism Awareness Month activities in April of 2021. The CNMI F2F focuses on building partnerships with parents to support parent leaders on Saipan, Tinian, and Rota. The F2F HIC faced some challenges during this project period with the departure of the program's Family Support Specialist (FSS). However, through the partnership with the CNMI Office of Vocational Rehabilitation (OVR), the F2F HIC program had recruited a temporary intern to help with many of the program's activities such as assisting with administrative duties, making reminder calls to families and assisting at outreach events.

In 2021, the F2F conducted 10 virtual learning sessions attended by families and professionals. The F2F leverages partnerships throughout the health department and external agencies to coordinate virtual training events.

Figure 4: F2F Learning Sessions offered in 10/2020-09/2021

Month	Topic	Title	Trainer/Facilitator	Participants
October 20		SPIN Conference	Online	4
November 20	Oral Health for CSHCN	Healthy Teeth is the Gateway to a Healthy Child	Dr. Angelica Sabino, DDS, Chief Dentist, CHCC	29
December 20	Childhood Nutrition	Kids & Food	Hannah Shai, Diabetes Prevention Program Coordinator	37
January 21	Emergency Preparedness for Individuals with Disabilities	Emergency Preparedness	Monika Diaz, CNMI VOICES Self-Advocate in partnership with CNMI UCEDD	27
March 21	Developmental Disabilities Awareness	Promoting Health: Children and Youth with Developmental Disabilities	Rachel Haynes, CHCC Nurse Practitioner	62
May 21	Newborn Screenings	Newborn Screenings and Why they are Important	Shiella Marie Deray, EHDI Program Coordinator	16
June 21	Health Services for Teens in the CNMI	Chasing Wellness	Kagman High School Youth Leaders, Youth Advisory Panel (YAP)	39
July 21	How to get and keep your family healthy and whole to start the school year	Take Good Care	Dr. Sarah Lewis	29
August 21	Overview of support and services provided to students with disabilities	SPED Program	Donna Flores, PSS Dir. of Special Education	48
September 21	Understanding ABA Therapy	ABCs of ABA Therapy	Doemiko Flores, Behavior Analyst	39

Collaboration with the medical providers, early intervention services, and 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.

Additionally, the CNMI Public School System SPED department serves as a significant partner in reaching children with special health needs and their families. In 2021, the MICAH unit partnered with the CNMI SPED program to distribute 175 headphones to children enrolled in SPED as part of efforts to support access to telehealth services, virtual learning sessions offered by MICAH, and virtual classes provided by PSS.

MCH Title V funding was used to support the salary of the Child Health Coordinator, who oversees the development and implementation of activities under this strategy.

Partnership with the CHCC Children's Clinic providers and nurses were strengthened in 2021. Ad-hoc meetings and monthly high-risk perinatal case conferences have helped to improve collaboration and awareness of emerging issues and to address gaps in services for women and children. 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.

MCH Title V funds are used to support the salaries of 3 Service Coordinators who receive referrals and provide families of CSHCN with support to navigate the healthcare system and other programs available to CSHCN.

Data gathered from the CNMI MCH Jurisdictional Survey indicated that only 14.1 percent of CSHCN, ages 0 through 17 in 2021 reported having a medical home. Data on the CNMI CSHCN population continues to be a challenge to report on and there have been shifts in the years' prior in identifying a data source to most accurately capture the percentage of children who identified as CSHCN and the percentage of CSHCN who reported having a medical home. In 2018, the program had partnered with the Public School System to survey the entire CNMI SPED population but unfortunately the disastrous super typhoon Yutu had caused major barriers in being able to return to the PSS SPED program to conduct the survey. In 2020, with the implementation of the MCH Jurisdictional Survey, the program transitioned to utilizing the information collected from the jurisdictional survey to inform the performance measure on medical home for CSHCN.

In 2021, as part of evaluation efforts, the F2F conducted a phone survey of families enrolled with the F2F to identify challenges families may have been facing due to the COVID-19 pandemic. Additionally, the survey collected information on families who reported that they had a medical home.

Figure 3: CNMI Medical Home Survey

Question	Yes	No	Unsure
1. During the past 12 months, has your child had a preventive care visit or WCC?	96.8%	3.2%	0
2. Where does your child receive health care services?	CHCC 77.8%	Private 3.2%	Both 19%
3. Does your child's health care provider make you feel like a partner with your child's care?	95.2%	0	4.8%
4. Does your CSHCN have multiple people from different disciplines working together to provide care for your child?	92.1%	4.8%	3.2%
5. Do you believe your CSHCN receives care in a well-functioning system?	81%	7.9%	11.1%

Source: CNMI F2F HIC Medical Home Survey

A total of 63 surveys were completed out of 88 households that were contacted. Overall, a majority of families enrolled surveyed responded to having a Medical Home and receiving coordinated services, figure 3.

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

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 FY2021 at local high schools were impacted due to the COVID-19 pandemic. Schools had to make periodic shifts from face to face learning to virtual learning and temporary school closures due to COVID-19 infections. Schools also prioritized efforts to minimize COVID-19 school transmissions and vaccination among its student population. As an alternative, the MICAH unit, as a member of the Disability Network Partners (DNP) coordinated Youth Transition Conferences held on Saipan, Tinian, and Rota. The conferences were attended by high school teens identified with disabilities, their parents, community members, and professionals within the community that provided services to individuals with disabilities. The Family Support Specialist and Child Health Coordinator conducted presentations at these conferences regarding healthcare and related services available for children and teens who have special healthcare needs and their families through the MICAH unit, including information on accessing support for healthcare 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.

Figure 6: Number of children screened with ASQ and identified as needing monitoring or below developmental cut-off, 2019 – 2021.

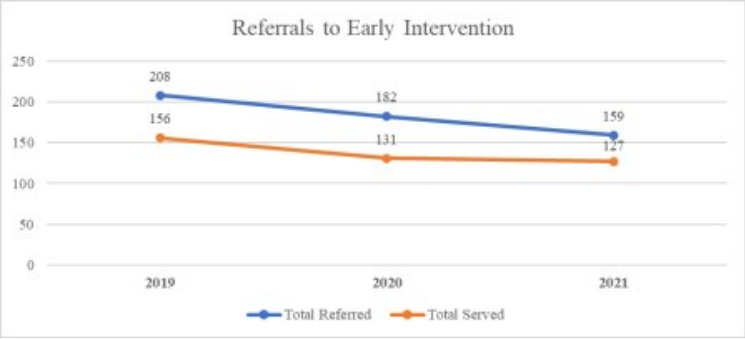
Year	Total Number Screened	Number Identified for monitoring or at below cut-off
2019	914	334
2020	1,256	389
2021	1,031	372

Source: MCH Program

In 2021, a total of 1,031 screenings were conducted at the Children's Clinic during Well Child Care. 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. 372 children identified as requiring additional monitoring or referral to Early Intervention services.

Early Intervention referral data reports a decrease in both the number of referrals to EI and the number of families served compared to the previous year. Due to the COVID-19 pandemic, EI services in the CNMI were temporarily suspended and eventually transitioned to virtual. During the mid-year, EI began providing face-to-face services to infants and toddlers who were enrolled into daycare settings.

Figure 7: Total Referrals to Early Intervention Services, 2019- 2021



Source: CNMI Early Intervention Program

A total of 127 families were served through the Early Intervention Program in during the school year 2020-2021. Of those families, 54 children were with established condition and 73 were identified as developmental delay. In 2021, 66% of infants and toddlers referred to EI were from the CHCC.

As in the previous year, 2021 data illustrates that 99% of babies born in the CNMI received a newborn hearing screening before one month of age. Of the babies screened, only one was diagnosed with hearing loss and was referred to the Early Intervention Program by 6 months of age. The CHCC-Early Hearing Detection & Intervention (EHDI) Program continues to meet the JCIH national benchmarks. Of the 5 babies that received a diagnostic audiological evaluation, 1 infant was diagnosed with hearing loss, 1 infant was lost to relocation and 3 infants had normal hearing, figure 8.

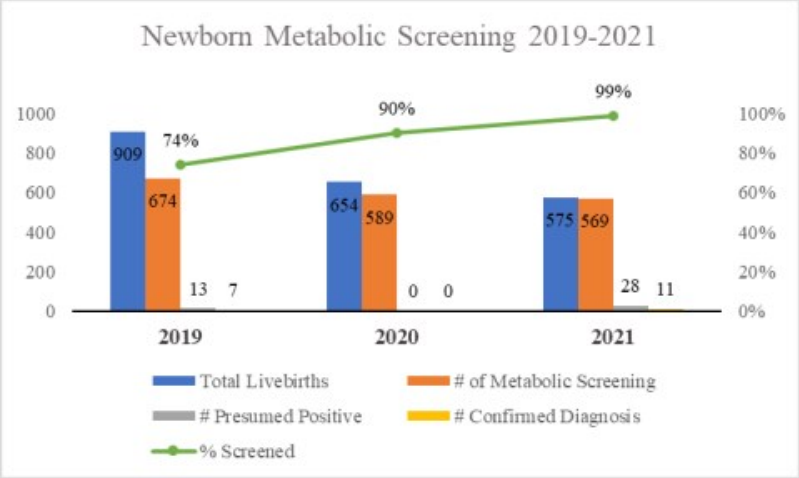
Figure 8: CNMI Newborn Hearing Screening, 2018- 2020

	2019	2020	*2021*
Births	909	654	575
Screened	903	648	569
Inpatient Pass	652	505	567
Inpatient Refer	247	138	100
Outpatient Pass	215	133	90
Outpatient LTFU	22	5	5
Outpatient Refer to DAE	11	5	5
DAE Pass	3	3	4
DAE Hearing Loss	10	1	1
EI Referral	9	1	1

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 9. Newborn Bloodspot Screening, 2019 - 2021



Data Source: CNMI Newborn Bloodspot Data

Of the 575 live births in 2021, 99% completed a newborn bloodspot screening. This is a significant increase compared to the prior year's rate and the year prior to that. Through the work of the CHCC chairwoman of pediatrics, Dr. Sadie LaPonsie, and Laboratory Director, Dr. Philip Dauterman, CHCC was able to modify its newborn bloodspot screening policy to enable daily shipment of bloodspot samples to the Oregon Public Health laboratory, causing decreases in lost to follow up among infants whose parents are asked to return for samples to be collected. When an NBS sample is detected to have an abnormal value, Oregon Public Health Laboratory alerts the Pediatrician and Program Coordinator to inform them to either have the infant get a second screen or for confirmatory testing. Of 28 infants that were presumed positive, 11 infants received a confirmed diagnosis and are being followed-up by a primary care provider. MCH Title V funds are used to support shipping costs for shipping newborn bloodspot samples. 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 the first quarter of 2021. In May 2021, a total of 83 children from ages 0 to 18 years of age were seen. Additionally, orthotic services were reinstated as the last orthotic visit to the CNMI was in 2019. Children who needed orthotics such as knee, foot and back braces were assessed and repairs and moldings were conducted. In addition to the outreach clinics, Shriners continued to provide telehealth services. Additionally, between October 2020 - September 2021, the MICAH CYSHCN unit worked collaboratively with the CNMI Medical Referral Program to send 9 patients to Honolulu despite COVID restrictions, so that the patients were able to complete the medical intervention needed.

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. Early intervention improves and enhances the development of a child with developmental delays, special needs, or other concerns. For MICAH, 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 that families are connected to resources and supports that empower them in taking an active role in the overall care of their children.

According to the 2021 Jurisdictional MCH Survey conducted, there were 14.1 percent of children with special health care needs, ages 0 through 17, who reported having a medical home in the CNMI. No substantia change in this percentage from the previous survey conducted in 2019 where just 13.3 percent of CSHCN reported having a medical home. The program has made efforts for improving in collaboration with the 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 challenges for the CNMI in FY2021 resulting from the COVID-19 pandemic that impacted the activities that were intended for the year and therefore some were carried into FY2022.

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 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 are children first.

Priority need 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 to 39% 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 specifically organizations that are a part of the Disability Network Partners (DNP).
There is evidence that community collaboration and outreach supports children receiving care within the medical home model resulting in increased contact with the medical home model for things like well-child visits, specialty care, disease management and oral health[1].

For FY 2023, October 2022 through September 2023, 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

- Develop outreach and referral protocol
- Establish partnership agreement with the Disability Network Providers for connecting CSHCN and their families to Family Support Services
- Conduct Outreach & In- Service Presentations to school teachers/staff and PTA groups. Participant information will be collected for follow-up surveys or input/feedback.
- Conduct evaluation or feedback survey on presentations and peer support services.
- Integrate screening for social determinants of health and implement referrals for families who identify a need for connecting with other available community services (i.e. Medicaid, education programs, housing programs, etc.)

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 64% and 51%, 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.

For FY 2023, October 2022 through September 2023, the following activities provide an outline of the strategy for 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

- 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
- Partner with the CNMI Disability Network Partners (DNP) to highlight healthcare transition during annual transition conferences.
- Work with the F2F to provide virtual learning sessions on transition to families.
- Conduct an assessment of 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.

[1] National Center for Education in Maternal and Child Health Georgetown University. (2019). Strengthen the Evidence Base for Maternal and Child Health Programs: Brief NPM 11. Retrieved on July 29, 2022 from https://www.mchevidence.org/documents/reviews/NPM-11-Medical-Home-Evidence-Brief.pdf

Cross-Cutting/Systems Building

State Performance Measures

SPM 2 - Percentage of CHCC Population 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
Annual Objective			10
Annual Indicator			2.1
Numerator			2
Denominator			94
Data Source			CHCC HUMAN RESOURCES
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0

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 Population Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.
Objectives
By 2025, at least 50% of CHCC PHS staff and MCH serving professionals will have completed training related to at least 75% of the CNMI MCH Title V population health domains.
Strategies
Implement a learning management system to provide training and capture completion rates

Cross-Cutting/Systems Builiding - Annual Report

One of the Key findings in the 2020 CNMI MCHB 5 - year needs assessment, suggest a need for healthcare professionals to have the knowledge and skills necessary to address the needs of maternal and child health populations. To improve the delivery of quality health services, and enhance skills, abilities, and performances of healthcare professionals, it is critical to establish effective training program not only to create a competent workforce, but also increases retention, moral 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.

After a careful review of SPM-2, an update to the original version was initiated to ensure consistent, timely, and accurate reporting. The updated version of SPM – 2 reads as follows:

State Performance Measure 2- Percentage of CHCC Population Health staff who received training on MCH priorities and/or related strategies.

Activities under the cross-cutting/systems building domain were impacted by the COVID-19 pandemic, in which Title V funded and MICAH programs staff were focused on the territorial effort to increase COVID-19 vaccination coverage and maintaining engagement with clients and community members as programs worked diligently in delivering services virtually.

In an assessment of the strategy and state performance measure (SPM) for this domain, it was determined that there was a need modify the SPM.

The updated SPM-2 narrows the eligibility of training participants to only, CHCC Population Staff (Denominator); and CHCC Population Staff who successfully completed the training (Numerator). This measure improves the specificity and attainability of SPM -2 objective.

CNMI MCH is investigating available options for providing online training to all MCH serving health professionals on health topics that include MCH priorities and/or other related strategies aimed at improving health outcomes for the MCH populations.

Moodle is a free open-source online learning platform that provides management with tools to promote professional development in the workplace. With Moodle, Instructors/management can create effective online courses aimed at enhancing knowledge and skills necessary to deliver quality health care services through professional development.

Cross-Cutting/Systems Building - Application Year

The 2020 MCH 5-year needs assessment indicated a need for trained and educated healthcare professionals at all levels to deliver healthcare services across all MCH population domains. State Performance Measure – 2 (SPM-2) addresses Priority Need 8 not provided in the National Performance Measure (NPMs).

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 Population Health staff who receive training on MCH priorities and/or related strategies.

Objectives: By 2025, increase the number of Population Health staff who complete training on MCH priorities to 25%.

Strategy: Provide training to CHCC Population Health staff.

Strategy: Provide training to CHCC Population Health workforce/staff members.

Training on MCH priorities will be offered to all CHCC staff with a targeted focus on MCH serving Population Health professionals. Topics will include: women's preventive care and screenings, breastfeeding, well-child checks and immunizations, behavioral health interventions for adolescents, transition services, medical homes, and other relevant materials to help support and promote maternal and child health in the CNMI.

For FY 2023, October 2022 through September 2023, the following activities provide an outline of the strategy to deliver training to CHCC Population Health staff:

MCH Training:

- Partner with the CHCC Professional & Development Coordinator and CE Coordinator to finalize a training schedule.
- Work with CHCC IT department to leverage the online Moodle platform to enable accessibility of MCH training materials.
- Develop communications materials to inform the CHCC workforce of available training courses online.
- Conduct monthly evaluation of training completion rates.

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.

In the past, the MCH Program participated in annual community events such as the Annual Red Cross Walk-a-Thon and Safe Jamboree. Since these events are attended by thousands of community members, the MCH Program participated 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. However, for the 2023 Application/2021 Annual Report, the MCH program did not have the opportunity to attend outreach events due to their cancellation as a result of the COVID-19 pandemic.

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 is 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. Copies of the draft application and annual report in its entirety is made available to anyone responding to the call for comments or public input.

The executive summary is also shared electronically, 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 CHCC will make the FY21 Annual Report/FY23 Annual Application available on the MICAH programs webpage of the CHCC website.

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 2021, 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 (HRSA). 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.

The CNMI MCH Program is currently conducting an assessment of staff capacity building and development needs and will be submitting TA requests based on the results of the assessment.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MEDICAID_MOU.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 Organizational Chart fy2021.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Northern Mariana Islands

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 466,540	
A. Preventive and Primary Care for Children	$ 144,274	(30.9%)
B. Children with Special Health Care Needs	$ 149,519	(32%)
C. Title V Administrative Costs	$ 42,004	(9.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 335,797	
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)	$ 479,204	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 479,204	
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	
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	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 8,875,751	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 2,793,609
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 93,175
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
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
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) > 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)	$ 3,187,632

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 465,091 (FY 21 Federal Award: $ 466,540)		$ 466,540	
A. Preventive and Primary Care for Children	$ 144,062	(31%)	$ 142,761	(30.5%)
B. Children with Special Health Care Needs	$ 146,866	(31.6%)	$ 149,145	(31.9%)
C. Title V Administrative Costs	$ 40,918	(8.8%)	$ 41,270	(8.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 331,846		$ 333,176	
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)	$ 475,634		$ 512,582	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 475,634		$ 512,582	
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)	$ 940,725		$ 979,122	
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)	$ 2,660,090		$ 6,730,842	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 3,600,815		$ 7,709,964	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000	$ 51,622
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 240,262
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,000,000	$ 822,633
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 296,400	$ 343,159
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 96,750	$ 119,371
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 981,940	$ 1,876,945
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)		$ 5,817
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)		$ 3,268,657
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)		$ 2,376

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budgeted amount previously reported did not include the supplemental funding received. The total expended amount includes the base plus the supplemental funding expended during the fiscal year 2021

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 53,372	$ 44,775
2. Infants < 1 year	$ 53,371	$ 44,774
3. Children 1 through 21 Years	$ 144,274	$ 142,761
4. CSHCN	$ 149,519	$ 149,145
5. All Others	$ 24,000	$ 43,815
Federal Total of Individuals Served	$ 424,536	$ 425,270

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 90,818	$ 93,267
2. Infants < 1 year	$ 90,818	$ 93,267
3. Children 1 through 21 Years	$ 171,301	$ 157,671
4. CSHCN	$ 126,267	$ 168,377
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 479,204	$ 512,582
Federal State MCH Block Grant Partnership Total	$ 903,740	$ 937,852

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 23 Application Budgeted	FY 21 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	$ 194,391	$ 223,913
3. Public Health Services and Systems	$ 272,149	$ 242,627
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 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	$ 466,540	$ 466,540

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 440,454	$ 472,567
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 142,886	$ 146,519
B. Preventive and Primary Care Services for Children	$ 171,301	$ 157,671
C. Services for CSHCN	$ 126,267	$ 168,377
2. Enabling Services	$ 0	$ 0
3. Public Health Services and Systems	$ 38,750	$ 40,015
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		$ 472,567
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		$ 472,567
Non-Federal Total	$ 479,204	$ 512,582

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: 575 **Data Source Year: 2021**

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	569 (99.0%)	28	11	11 (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)	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 1	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	569 (99.0%)	5	1	1 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

There is no practice for monitoring infants with confirmed diagnosis, including what information is obtained and for how long infants are monitored.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2021**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: The data represents the total number of live births in the CNMI, Health and Vital Statistics Office.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2021**
	Column Name:	**Data Source Year Notes**
	Field Note: Reporting year	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: The value represent the total number of infants who received at least one valid Newborn screening.	
4.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: The value represents the total number of infants with out-of-range results originating from the total number of infants who received at least one valid screen.	
5.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: Value represents the total number of confirmed cases	
6.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2021**

	Column Name:	**Core RUSP Conditions**
	Field Note: The value represents the total number of infants referred for treatment.	
7.	**Field Name:**	**Newborn Hearing Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: The value represent the total number of infants who received at least one Newborn Hearing screening.	
8.	**Field Name:**	**Newborn Hearing Screening - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: The value represent the total number of infants with presumptive positive screening results.	
9.	**Field Name:**	**Newborn Hearing Screening - Total Number Confirmed Cases**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: The value represents the total number of infants with confirmed cases.	
10.	**Field Name:**	**Newborn Hearing Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: The value represents the total number of infants referred for treatment.	

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 2021

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	572	75.0	0.0	13.0	12.0	0.0
2. Infants < 1 Year of Age	575	75.0	0.0	13.0	12.0	0.0
3. Children 1 through 21 Years of Age	14,545	48.0	0.0	19.0	33.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,237	0.0	0.0	0.0	0.0	100.0
4. Others	23,460	40.4	0.0	45.3	14.3	0.0
Total	39,152					

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	783	No	572	100.0	572	572
2. Infants < 1 Year of Age	767	No	575	100.0	575	575
3. Children 1 through 21 Years of Age	18,417	No	18,188	80.0	14,550	14,545
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,400	No	1,237	100.0	1,237	1,237
4. Others	32,667	No	32,699	72.0	23,543	23,460

^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:	**2021**
	Field Note: The value represents the total number of women who gave birth at CHCC. Data Source: HVSO 2021 Live birth dataset	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	Field Note: The value represents the total number of infants born at CHCC. Data source - HVSO 2021 Live birth dataset	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: The value represents the total number of children ages 1 through 21 years who received health care service at CHCC. Data notes: Due to Electronic Health Record (EHR) upgrades, 75% of data (from January through September 2021) originated from the Indian Health Service RPMS/EHR; the remaining 25%, (October through December 2021), derived from the current CareVue - Revenue Cycle Management RCM/EHR.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: The value represents the total number of children ages 1 through 21 years of age who were enrolled at Early Intervention (EI) and Special Education (SPED) for school year 2021-2022	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**
	Field Note: The value represents the number of women and men ages 22 years and above, who were seen for COVID-19 vaccinations including Dental, Immunization, Family Planning, General, Nurse, Women's Clinic, and Mental/behavioral health care services.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**
	Field Note: The value reflects the percentage of pregnant women served by Title V funds through direct and enabling services for women who access health services at Commonwealth Healthcare Corporation, which operates the only birthing facility in the CNMI.	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2021**
	Field Note: The value represents the total number of women who gave birth at CHCC. Data Source: 2021 HVSO Live birth dataset	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**
	Field Note: The value represents the total number of infants less than 1 year old who were served during well-child visits at the CHCC children's clinic including dental visit by the Public Health dental clinic through the Oral Health Program.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2021**
	Field Note: The value represents the total number of live births at CHCC. Data Source: 2021 HVSO livebirth dataset	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: Value is based on the total number of children ages 1 through 21 years of age who were served at Commonwealth Health Care Corporation (CHCC) in 2021.	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2021**
	Field Note: Data source: Numerator: Number of children ages 1 through 21 who visited CHCC for health care services; 2021-CHCC RPMS Data. Denominator: 2021, US International Census Bureau Population Estimate for Children 1-21 years.	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**

	Fiscal Year:	**2021**
	Field Note: Value is based on total number of CSHCN who were provided care coordination services.	
8.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Denominator**
	Fiscal Year:	**2021**
	Field Note: The value represents the total number of Children who were enrolled in Early Intervention and Special Education for School year 2021-2022	
9.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**
	Field Note: The value represents the percentage of men and women ages 22 years and above, who were seen for COVID-19 and other required vaccination; as well as those who visited the Dental, Immunization, Family Planning, General, Nurse and Women's Clinic, and Mental/behavioral health care services. Denominator - 2021 U.S. International Census Bureau Population Estimates for ages 22 years and above	
10.	**Field Name:**	**Others Denominator**
	Fiscal Year:	**2021**
	Field Note: Denominator: 2021, US International Census Bureau Population Estimate for all men and women ages 22 years and older.	

Data Alerts:

1.	Pregnant Women Denominator is less than or equal to 90% of the Pregnant Women Reference Data. Please double check and justify with a field note.
2.	Infants Less Than One Year Denominator is less than or equal to 90% 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 1 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
7.	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.
8.	Others, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
9.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

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

State: Northern Mariana Islands

Annual Report Year 2021

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	572	10	0	0	0	218	302	42	0
Title V Served	572	10	0	0	0	218	302	42	0
Eligible for Title XIX	431	2	0	0	0	151	242	36	0
2. Total Infants in State	575	10	0	0	0	219	303	43	0
Title V Served	575	10	0	0	0	219	303	43	0
Eligible for Title XIX	433	2	0	0	0	151	243	37	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

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

State: Northern Mariana Islands

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(670) 287-7718	(670) 287-7718
2. State MCH Toll-Free "Hotline" Name	MCH Services	MCH Services
3. Name of Contact Person for State MCH "Hotline"	Antonio Yarobwemal	Antonio Yarobwemal
4. Contact Person's Telephone Number	(670) 287-7718	(670) 287-7718
5. Number of Calls Received on the State MCH "Hotline"		1,296

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://www.chcc.health/maternalchildhealth.php	https://www.chcc.health/maternalchildhealth.php
4. Number of Hits to the State Title V Program Website		836
5. State Title V Social Media Websites	https://www.facebook.com/cnmipophealth	https://www.facebook.com/cnmipophealth
6. Number of Hits to the State Title V Program Social Media Websites		134,083

Form Notes for Form 7:

Data on social media website hits is based on the total number of daily unique users to the agency's Facebook page who had any content from the page or about the page enter their screen. This includes posts, check-ins, ads, social information from people who interact with the page and more.

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 of Population Health Services
Address 1	Po Box 500409
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 236-8703
Extension	
Email	heather.pangelinan@chcc.health

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Shiella Deray
Title	Coordinator
Address 1	Po Box 500409
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 236-8723
Extension	
Email	shiella.deray@chcc.health

3. State Family or Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Northern Mariana Islands

Application Year 2023

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 adverse birth outcomes through Prenatal Care.
4.	Obesity related issues including nutrition and physical activity
5.	Coping skills and suicide prevention
6.	Support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful.
7.	Helping parents/caregivers navigate the health care system for coordinated care
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.

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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**
2021	98.3 %	1.7 %	1,972	2,007

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2021
Annual Indicator	66.8
Numerator	382
Denominator	572
Data Source	HVSO LIVE BIRTH DATASET
Data Source Year	2021

NOM 1 - Notes:

Numerator Number pregnant women who received prenatal checkup during the 1st trimester (before 13 weeks' gestation) in year 2021.

Denominator: Total number of pregnant women in year 2021.

Data Alerts: None

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

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

State Provided Data	
	2021
Annual Indicator	260.9
Numerator	15
Denominator	575
Data Source	HVSO Live birth dataset
Data Source Year	2021

NOM 2 - Notes:

Numerator include the number of deliveries with an indication of hypertension eclampsia, maternal transfusion, ruptured uterus, unplanned hysterotomy, admission to ICU, and unplanned OR procedures

Denominator: number of live births

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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	
	2021
Annual Indicator	173.9
Numerator	1
Denominator	575
Data Source	HVSO Summary of Mortality Rate
Data Source Year	2021

NOM 3 - Notes:

Numerator: number of pregnancy related deaths not due to accidental or incidental causes and occurring within 42 days of the end of a pregnancy.

Denominator: Number of live births

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2021	13.3 %	2.5 %	2,277	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	
	2021
Annual Indicator	8.2
Numerator	47
Denominator	575
Data Source	HVSO Live birth dataset
Data Source Year	2021

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2021	15.5 %	2.2 %	2,666	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	
	2021
Annual Indicator	8.9
Numerator	51
Denominator	575
Data Source	HVSO Live birth dataset
Data Source Year	2021

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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	
	2021
Annual Indicator	29.2
Numerator	168
Denominator	575
Data Source	HVSO live birth dataset
Data Source Year	2021

NOM 6 - Notes:

None

Data Alerts: None

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

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

NOM 7 - Notes:

None

Data Alerts: None

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

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	
	2021
Annual Indicator	17.3
Numerator	10
Denominator	579
Data Source	HVSO Summary of Mortality Rate
Data Source Year	2021

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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	
	2021
Annual Indicator	12.2
Numerator	7
Denominator	575
Data Source	HVSO Summary of Mortality Rate
Data Source Year	2021

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	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	
	2021
Annual Indicator	10.4
Numerator	6
Denominator	575
Data Source	HVSO summary of Mortality Rate
Data Source Year	2021

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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	
	2021
Annual Indicator	1.7
Numerator	1
Denominator	575
Data Source	HVSO Summary of Mortality Rate
Data Source Year	2021

NOM 9.3 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2021
Annual Indicator	695.7
Numerator	4
Denominator	575
Data Source	HVSO Summary of Mortality Rate
Data Source Year	2021

NOM 9.4 - Notes:

Numerator is based on certain condition originating in the perinatal period (less than 37 completed weeks of gestation).

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

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

State Provided Data	
	2021
Annual Indicator	0.0
Numerator	0
Denominator	572
Data Source	HVSO live birth dataset
Data Source Year	2021

NOM 10 - Notes:

Of the 572 women who gave birth in 2021, none indicated that they drank alcohol in the last 3 months of their pregnancy

Data source: 2021 HVSO Live Birth dataset

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 10. Please review your data to ensure this is correct.

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

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

NOM 11 - Notes:

State data not available at this time, SSDI is currently discussing options with Health and Vital Statistics Office on identifying data sources for capturing the rate of neonatal abstinence syndrome

Data Alerts:

1.	Data has not been entered for NOM 11. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

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

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

NOM 13 - Notes:

None

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	17.0 %	2.8 %	2,728	16,051

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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	
	2021
Annual Indicator	44.9
Numerator	3
Denominator	6,675
Data Source	HVSO summary mortality rate
Data Source Year	2021

NOM 15 - Notes:

Numerator: HVSO summary mortality rate

Denominator U.S. International population estimate census

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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	
	2021
Annual Indicator	0.0
Numerator	0
Denominator	9,792
Data Source	HVSO summary mortality rate
Data Source Year	2021

NOM 16.1 - Notes:

There were no mortality for adolescent ages 10 through 19 in year 2021.

Numerator: 20221 HVSO summary mortality rate
Denominator: 2021 U.S. International population estimate census.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 16.1. Please review your data to ensure this is correct.

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2021
Annual Indicator	0.0
Numerator	0
Denominator	4,741
Data Source	HVSO Summary mortality rate
Data Source Year	2021

NOM 16.2 - Notes:

There were no incident of mortality for adolescent ages 15 through 19 in year 2021.
Numerator: 20221 HVSO summary mortality rate
Denominator: 2021 U.S. International population estimate census.

Data Alerts:

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

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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
2008_2010	NR	NR	NR	NR
2007_2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2021
Annual Indicator	0.0
Numerator	0
Denominator	4,741
Data Source	HVSO Summary mortality rate
Data Source Year	2021

NOM 16.3 - Notes:

There were no suicide for Adolescent ages 15 through 19 in year 2021.

Numerator: 20221 HVSO summary mortality rate
Denominator: 2021 U.S. International population estimate census.

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	7.3 %	1.6 %	1,252	17,149

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

NOM 17.2 - Notes:

The MCH-JS 2021 was the data source for this measure, the survey estimates indicated a value of zero (0), however, the indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution.

The CSHCN coordinator will conduct a Family 2 Family survey to track the outcome of this measure.

Data Alerts:

1.	Data has not been entered for NOM 17.2. This outcome measure is linked to the selected NPM 13.2,11,10,12,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	0.2 %	0.2 %	23	14,137

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	3.5 %	1.5 %	502	14,137

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	7.5 %	7.5 %	30	396

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	72.0 %	2.9 %	12,340	17,149

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 <50 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
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
2021	24.1 %	4.2 %	1,857	7,709

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	6.2 %	1.6 %	1,066	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	
	2021
Annual Indicator	26.7
Numerator	4,134
Denominator	15,490
Data Source	CHCC RPMS/U.S. International estimate census
Data Source Year	2021

NOM 21 - Notes:

Numerator: CHCC RPMS - number of children ages 0 through 17 who were seen a CHCC in year 2021

Denominator: US International estimate census - total number of children ages 0 through 17 years

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

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

State Provided Data	
	2021
Annual Indicator	70.0
Numerator	1,181
Denominator	1,686
Data Source	CHCC Weblz
Data Source Year	2021

NOM 22.1 - Notes:

Numerator: Number of children ages 19-35 months who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Denominator: Number of children ages 19-35 months registered into the CNMI Immunization registry (Weblz).

Data Alerts: None

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

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

State Provided Data	
	2021
Annual Indicator	28.3
Numerator	4,391
Denominator	15,540
Data Source	CHCC WebIz
Data Source Year	2021

NOM 22.2 - Notes:

Numerator: Number of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Denominator: Number of children, ages 6 months through 17 years who were enrolled in WebIz Immunization Program

Data Alerts: None

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

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

State Provided Data	
	2021
Annual Indicator	95.5
Numerator	4,649
Denominator	4,870
Data Source	CHCC WebIz
Data Source Year	2021

NOM 22.3 - Notes:

Numerator: Number of adolescents, ages 13 through17 years, who have received at least one dose of the HPV vaccine

Denominator: Number of children, 13 through 17 years who were enrolled in WebIz Immunization Program

Data Alerts: None

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

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

State Provided Data	
	2021
Annual Indicator	97.7
Numerator	4,758
Denominator	4,870
Data Source	CHCC Weblz
Data Source Year	2021

NOM 22.4 - Notes:

Numerator: Number of adolescents, ages 13 through 17 years, who have received at least one dose of the Tdap vaccine

Denominator: Number of children, ages 13 through 17 years who were enrolled in Weblz Immunization Program

Data Alerts: None

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

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

State Provided Data	
	2021
Annual Indicator	98.0
Numerator	4,775
Denominator	4,870
Data Source	CHCC WebIz
Data Source Year	2021

NOM 22.5 - Notes:

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

Denominator Number of adolescents, ages 13 through17 years enrolled in WebIz Immunization Program

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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	
	2021
Annual Indicator	13.0
Numerator	28
Denominator	2,147
Data Source	HVSO Live birth dataset
Data Source Year	2021

NOM 23 - Notes:

Numerator Number of resident/temporary resident adolescents, females ages 15 through 19 years who gave birth.

Denominator Number of adolescent females, ages 15 through 19 years (U.S. International estimate census)

Data Alerts: None

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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	33.8 % ϟ	10.6 % ϟ	678 ϟ	2,007 ϟ

Legends:

ϟ Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	5.6 %	1.8 %	962	17,149

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Northern Mariana Islands

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

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS)			
	2019	**2020**	**2021**
Annual Objective		56	57
Annual Indicator	55.5	55.5	57.1
Numerator	6,544	6,544	7,415
Denominator	11,784	11,784	12,993
Data Source	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	12	19	20	56	57
Annual Indicator	18.1	18.7	19.7	41.9	65.7
Numerator	1,425	1,437	1,516	3,238	5,071
Denominator	7,863	7,690	7,689	7,721	7,717
Data Source	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CHCC Preventive Visits and US international census	CHCC EHR/RPMS Preventive visits
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	59.0	61.0	63.0	65.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Numerator data obtained from the CHCC RPMS Database and the Family Planning Program FPAR database. Denominator data from the 2010 US Census Population Estimator Database. Data is for CY 2017. Numerator information does not include data for women who might have had a preventive visit at a private clinic. Please note a significant decrease in the Census population estimate (denominator) between years 2016 and 2017 by 4,233.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The CNMI has no current population based data for this NPM. A proxy measure, number of pap exams completed, is used to report on this measure. Numerator data obtained from CNMI Pap Exam Lab Test Data. Denominator data from the 2010 US Census Population Estimator Database. Data is for CY 2017. Please note a significant decrease in the Census population estimate (denominator) compared to year 2016.	
3.	**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	
4.	**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.	

NPM 4A - Percent of infants who are ever breastfed

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

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	94	96	96	97	97
Annual Indicator	94.7	95.8	96.5	93.3	93.7
Numerator	1,145	1,209	877	610	539
Denominator	1,209	1,262	909	654	575
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	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	98.0	98.0	98.0	98.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data for this National Performance Measure obtained through the CNMI Health and Vital Statistics Office. The denominator value is based on the total number of live births in the CNMI for CY2017. Numerator value is based on the total number of infants breastfed at discharge after delivery by HVSO.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data for this National Performance Measure obtained through the CNMI Health and Vital Statistics Office. The denominator value is based on the total number of live births in the CNMI for CY2018. Numerator value is based on the total number of infants breastfed at discharge after delivery by HVSO.	
3.	**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	

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

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

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	3	4	4	5	5
Annual Indicator	2.5	2.5	1.1	0.4	0
Numerator	13	12	5	2	0
Denominator	518	486	470	544	419
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.0	6.0	7.0	7.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Numerator data source is the CNMI WIC program and represents that number of enrolled 6 month old infants during the reporting year who were exclusively breastfed through 6 months. Denominator data represents the number of 6 month old infants enrolled in WIC during the reporting year.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator data source is the CNMI WIC program and represents that number of enrolled 6 month old infants during the reporting year who were exclusively breastfed through 6 months. Denominator data represents the number of 6 month old infants enrolled in WIC during the reporting year.	
3.	**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.	

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD			
	2019	**2020**	**2021**
Annual Objective			55
Annual Indicator	52.7	52.7	43.5
Numerator	2,769	2,769	2,393
Denominator	5,253	5,253	5,498
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019	2021

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	57.0	59.0	61.0	63.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS)			
	2019	**2020**	**2021**
Annual Objective			43
Annual Indicator	42.4	42.4	39.3
Numerator	2,593	2,593	2,156
Denominator	6,119	6,119	5,493
Data Source	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021

State Provided Data			
	2019	**2020**	**2021**
Annual Objective			43
Annual Indicator	19.1	6.8	22
Numerator	1,167	424	1,378
Denominator	6,094	6,215	6,256
Data Source	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	RPMS AND US INTERNATIONAL CENSUS ESTIMATES	RPMS AND US INTERNATIONAL CENSUS ESTIMATES
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	46.0	49.0	52.0	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	

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

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

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		49	20	15	19
Annual Indicator	46.8	19.6	19.6		
Numerator	37	54	54		
Denominator	79	276	276		
Data Source	CYSHCN Survey	CSHCN Survey	CSHCN Survey		
Data Source Year	2017	2018	2019		
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	15.0	18.0	21.0	25.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	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.	
2.	**Field Name:**	**2018**
	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.	
3.	**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 12 - 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 - Children with Special Health Care Needs

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN			
	2019	**2020**	**2021**
Annual Objective			52
Annual Indicator	51.0	51.0	32.8
Numerator	183	183	167
Denominator	358	358	511
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	55.0	58.0	61.0	64.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - 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 - Adolescent Health - NONCSHCN

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS) - NONCSHCN			
	2019	**2020**	**2021**
Annual Objective			49
Annual Indicator	48.4	48.4	46.3
Numerator	2,788	2,788	2,306
Denominator	5,761	5,761	4,982
Data Source	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN
Data Source Year	2019	2019	2021

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	52.0	55.0	58.0	61.0

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	45	47	49	51	53
Annual Indicator	45.8	47.5	47.9	55	67
Numerator	297	323	334	347	381
Denominator	648	680	697	631	569
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	70.0	72.0	74.0	75.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Denominator value based on the total number of resident live births. Numerator value based on the number of resident live births with prenatal care beginning in the first trimester as completed on the birth certificates.	
2.	**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.	
3.	**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.	

SPM 2 - Percentage of CHCC Population 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
Annual Objective			10
Annual Indicator			2.1
Numerator			2
Denominator			94
Data Source			CHCC HUMAN RESOURCES
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Training on using / entering data into the new electronic health record (CareVue) revenue cycle management (RCM) 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.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Northern Mariana Islands

ESM 1.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at CHCC clinics during extended hours and/or outreach events

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			5
Annual Indicator			0
Numerator			0
Denominator			7,717
Data Source			CHCC Clinics and Outreach events query records
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	49.0	50.0	51.0	52.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Activities involving ESM 1.1 was interrupted due to COVID-19 PANDEMIC; activities will resume at a later date.

ESM 4.1 - Percentage of infants who were breastfed at 6 months.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			10
Annual Indicator			57.1
Numerator			238
Denominator			417
Data Source			WIC Program
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	57.4	57.6	57.8	58.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Activities surrounding ESM 4.1 was delayed due to COVID-19 PANDEMIC; activities for this measure will resume at a later date.

ESM 8.1.1 - 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
Annual Objective			10
Annual Indicator			0
Numerator			0
Denominator			142
Data Source			MCH referral log and EFNEP enrollment record
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
MCH is collaborating with Northern Marianas College (NMC) to increase enrollment of parents/caregivers into the Expanded Food and Nutrition Education Program (EFNEP), an evidence based nutrition program. Activities for this measure were delay due to the Covid-19 pandemic.

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			10
Annual Indicator			0
Numerator			0
Denominator			1,378
Data Source			MCH service coordinator/EHR
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1.0	0.9	0.8	0.7

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 10.1 is postponed to a later date.

ESM 11.1 - 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
Annual Objective			10
Annual Indicator			81
Numerator			51
Denominator			63
Data Source			F2F Medical Home Survey
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	20.0	30.0	40.0	50.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.1 - Percent of adolescents ages 12 through 17 years with and without special healthcare needs whose families reported increased knowledge about the importance of transition after presentations.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			10
Annual Indicator			0
Numerator			0
Denominator			5,493
Data Source			Pre-Post survey
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	20.0	25.0	30.0

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.

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 Population 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, at least 50% of CHCC PHS staff and MCH serving professionals will have completed training related to at least 75% of the CNMI MCH Title V population health domains.
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 1.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at CHCC clinics during extended hours and/or outreach events
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

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 during CHCC clinics extended hours and/or outreach events **Denominator:** Number of women ages 18-44 years
Data Sources and Data Issues:	The data source is Women's Health Survey administered online, and on paper format to women ages 18 years and older, including those who all visited the CHCC health department/clinics, and MICAH internal and external partners during the past year to present.
Evidence-based/informed strategy:	ESM 1.1 measures the number of women ages 18-44 years who access preventive care visit at CHCC during extended hours and outreach events; 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 4.1 - Percentage of infants who were breastfed at 6 months.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase of the number of infants breastfed through 6 months
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants who were 3 months breastfed. **Denominator:** Total number of infants
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 8.1.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase enrollment in an evidence-based nutrition and physical activity program.
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 referrals who reported completing at least 75% of the EFNEP program curriculum.</td></tr><tr><td>**Denominator:**</td><td>Number of referrals to the EFNEP program</td></tr></table>
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 10.1 - Percentage of adolescents accessing preventive care through referrals from the Public School System (PSS)
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The goal is to reduce youth suicide rate among adolescent by working with Public School System to increase preventive care visits that provides behavioral health screenings and assessments.</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 adolescent who were referred by Public School System for prevent care visit</td></tr>
<tr><td>Denominator:</td><td>Number adolescent who access preventive care visit.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Records of MCH service coordinator and EHR</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The ESM measures the the number of adolescent who were referred to MCH coordinator to access preventive care visit that allows providers to conduct behavioral/mental health screening, and assessment focused on improving the patient's health and well-being holistically.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 11.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	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:	<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 families served by the Family to Family Health Information Center who reported having a medical home.</td></tr><tr><td>**Denominator:**</td><td>Number of families served by Family to Family Health Information Center.</td></tr></table>
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 12.1 - Percent of adolescents ages 12 through 17 years with and without special healthcare needs whose families reported increased knowledge about the importance of transition after presentations.
NPM 12 – 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

Measure Status:	Active
ESM Subgroup(s):	CSHCN and non-CSHCN
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 adolescents with or without special health care needs, ages 12 through 17, whose families reported increased knowledge about the importance of transition after presentations. **Denominator:** Number of adolescents ages 12 through 17 years with or without special health care needs attending the presentation
Data Sources and Data Issues:	A survey instrument will be used to collect data after each presentation
Evidence-based/informed strategy:	Number of adolescents and families who reported increase knowledge of the importance of transition can be obtained from a Pre and post survey results given after each presentation that aims to improve awareness to the 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
MCH Data Access and Linkages

State: Northern Mariana Islands

Annual Report Year 2021

	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	3		
2) Vital Records Death	Yes	Yes	Annually	12	Yes	
3) Medicaid	Yes	Yes	Monthly	12	No	
4) WIC	Yes	Yes	Annually	12	No	
5) Newborn Bloodspot Screening	Yes	Yes	Monthly	1	No	
6) Newborn Hearing Screening	Yes	Yes	Monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Monthly	1	No	
8) PRAMS or PRAMS-like	No	No	Never	NA	Yes	

Other Data Source(s) (Optional)

	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
9) Developmental Screening	Yes	Yes	Monthly	1	No	
10) Immunization Information System	Yes	Yes	Daily	1	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	8) PRAMS or PRAMS-like
	Field Note: PRAMS survey being administered in the CNMI beginning with 2022 births. This report on data access to PRAMS or PRAMS like data may be revised in the upcoming reporting year.

Other Data Source(s) (Optional) Field Notes: