Maternal and Child Health Services Title V Block Grant

Northern Mariana Islands

FY 2024 Application/ FY 2022 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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

CEO-L23-955

July 24, 2023

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

Subject: HRSA Announcement No. HRSA-24-001 / Tracking No. 216285

Dear Dr. Warren,

The Commonwealth of the Northern Mariana Islands' (CNMI) Commonwealth Healthcare Corporation (CHCC) is pleased to submit the FY 2024 Title V Block Grant Application /FY 2022 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, 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, and we look forward to working together more in the future. Should you have any questions or need more information, please feel free to contact our program at your convenience.

Sincerely,

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

P.O. Box 500409 CK, Saipan, MP 96950
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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: January 31, 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 Public Health Services Director designated as the Project Director. Federal regulations require that at least 30% of the funding must be used for services and programs for children and another 30%, at a minimum, must be used for services and programs for CYSHCN. No more than 10% may be used for administrative costs. Jurisdictions must provide a $3 match for every $4 in federal funds received. Although there are no minimum spending requirements, funding is also to be spent on preventive and primary care services for pregnant women, mothers, and infants up to age one. The CNMI MCH Block Grant funds support state and local program and staff, and are administered by the Maternal, Infant, Child and Adolescent Health (MICAH) unit of the Commonwealth Healthcare Corporation (CHCC).

Every five years, the CHCC conducts a comprehensive, statewide needs assessment to assess the gaps in needs, strengths, and limitations of services available to MCH populations across six domains. The CNMI uses the "Title V Needs Assessment, Planning Implementation, and Monitoring Framework" to guide the needs assessment and program planning process for each five-year cycle, with emphasis placed on engaging stakeholders and community partners. For the 2020 Needs Assessment, the MCH Program contracted with a consultant to conduct needs assessment activities, assist with building the state action plan, and 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. The 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 2016 CNMI NCD data of only **43.2% of women reporting completing pap testing** within the past 2 years, and was ranked high for feasibility and impact as well as program capacity to affect change. Additionally, 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 1: Ability to find and see a doctor when needed (access to health services)

National Performance Measure 1: Percentage of women ages 18-44 years with a past year preventive visit.
Objectives: By 2025, increase the percentage of women who access preventive visits to 65%, an increase from the baseline of 55%.
Strategy: Expand access: Outreach and/ or increased clinic hours.
For FY2024, the CHCC PHS will conduct the following activities to improve women's health:

- **Utilization 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, education and support for breastfeeding and prenatal care were identified as priorities for the CNMI. Early identification of developmental delays and the need for intervention services (ranked first), reducing infant mortality (ranked third), services and treatment for babies born exposed to certain substances such as alcohol or drugs (ranked fourth), and education and services to help prevent and care for premature babies (ranked seventh). These issues were combined into the following priorities for which MCH has program capacity to affect change. This combined priority ranked high for feasibility and impact. In 2021, **first trimester prenatal care was at 67% and in 2022 slightly decreased to 62%.** Infant mortality was at 12.7 per 1,000 live births in 2022. Because CNMI does not have a level III neonatal intensive care unit, this priority will be a State Performance Measure (SPM) evaluated by early prenatal care.
Priority Need 2: Breastfeeding
National Performance Measure 4 – A) Percent of infants who are ever breastfed and
B) Percent of infants breastfed exclusively through 6 months
Objective: By 2025, increase of the percentage of infants breastfed through 6 months to 54%, an increase from the baseline of 44%.
Strategy: Implement workplace breastfeeding policies/support
For FY2024, 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 3: Prevention of adverse birth outcomes through Prenatal Care.
State Performance Measure 1: Percent of live births to resident women with first trimester prenatal care.
Objective: By 2025, increase the number of pregnant women with first trimester prenatal care to 75%, an increase from the baseline percentage of 55%.
Strategy: Provide service navigation for pregnant women.
For FY2024, the CHCC PHS will conduct the following activities to improve prenatal care rates:

- **Provide service coordination support 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.

In addition, 31.5% of public input survey respondents in 2020 did not believe children of the CNMI have access to healthy physical activities.

Although nutrition/ food security and obesity was ranked high for feasibility and impact as well as program capacity to affect

change, safe schools and neighborhood programs was not.

Though the CHCC has limited capacity to affect change to physical and structural barriers, it was determined that promotion of the safe physical activity options that do exist was a valid priority for this population. This priority aligns with NPM #8- Physical activity.
Priority Need 4: Obesity related issues including nutrition and physical activity
National Performance Measure 8- Percent of children ages 6 through 11 years who are physically active at least 60 minutes per day.
Objective: By 2025, increase the percentage of children ages 6 through 11 years who report being active at least 60 minutes a day to 63%, an increase from the baseline percentage of 53%.
Strategies: Enhance partnerships with CNMI youth serving agencies or organizations to provide more opportunities for physical activity among children 6 through 11 years.
For FY2024, 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, 2021CNMI YRBS data shows that 29% of CNMI high school student reported seriously considering attempting suicide, a slight increase from 28.5% reported in 2019. Suicide prevention was also ranked high for feasibility and impact as well as program capacity to affect change. This priority aligns with NPM #10- Adolescent well-visit. MCH intends to promote well visits for adolescents at which a holistic approach including promoting coping skills and preventing suicide as part of a behavioral health screening and assessment to be conducted at the well-visit.
In addition, Priority Need 7, Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful was determined to be an area of focus for adolescents with and without special healthcare needs that needed to be addressed.
Priority Need 5: Coping Skills and Suicide Prevention
National Performance Measure 10: Percent of adolescents, ages 12 through 17 years, with a preventive medical visit in the past year.
Objective: By 2025, increase the percentage of adolescents who access well visits to 55%, an increase from the baseline of 42%.
Strategy: Work with partners to increase the number of adolescents accessing adolescent health visits.
For FY2024, 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 7: Support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful.
National Performance Measure 12: Transition- Percent of adolescents with and without special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care.
Objective: By 2025, increase the percentage of adolescents ages 12 through 17 years with and without special healthcare needs who receive transition services to 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 FY2024, the CHCC PHS will conduct the following activities to improve the percentage of teens accessing transition services:

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

CHILDREN WITH SPECIAL HEALTHCARE NEEDS (CSHCN) Coordinated care and assisting parents and caregivers navigate the health care system was chosen as the priority for the children with special health care needs domain. It was the primary priority identified by the public input survey, shows room for improvement based on the data from the CNMI MCH survey identifying **only 14.1% of children with special health care needs reported having a medical home,** the vast array of programs and agencies that contribute to services in this domain, and was ranked high for feasibility and impact as well as program capacity to affect change. This priority aligns with NPM #11- Medical home.
Priority Need 6: Helping parents/caregivers navigate the healthcare system
National Performance Measure 11: Percent of CSHCN ages 0 through 17 years who have a medical home.
Objective: By 2025, increase the percentage of CSHCN who report having a medical home to 25%, an increase from a baseline percentage of 14%.
Strategy: Conduct outreach and provide peer support to families of children and youth with special healthcare needs.
For FY2024, 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 priority need 8. Participants voiced a need for trained, qualified professionals who could deliver services across domains. This incorporates the survey findings related to priority, family engagement and parent education. The second priority topic chosen by respondents was better and clearer communication about healthy behaviors, health services and supports available in the community. Community outreach was chosen as the preferred method for family engagement with 72.7% of respondents choosing that method. Home visiting was chosen as the preferred method of receiving parent education with 57.6% of respondents choosing that method.
Priority Need 8: Professionals have the knowledge and information to address the needs of maternal and child health populations
State Performance Measure 2- Percentage of CHCC Public Health Services (PHS) staff who complete training on MCH priorities and related topics.
Objectives: By 2025, 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 FY2024, 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

Increasing access to life saving screening for infants in the CNMI

The CNMI has seen tremendous success in improving the rate of newborn bloodspot screenings conducted for babies born in the territory. In 2022, almost all babies born in the CNMI (99.8%) had received a newborn bloodspot screening after birth. This number is a huge contrast to just five years ago when less than half (41.8%) of all babies born were screened (reference Table 1. below).

Table1. Percentage of live births completing a Newborn Bloodspot Screening in the CNMI

Year	2018	2019	2020	2021	2022
# Screened	527	674	589	569	472
# of live births	1,262	909	654	575	473
%Screened	**41.8%**	**74.1%**	**90.0%**	**98.9%**	**99.8%**

Source: CNMI EHDI-IS

The CNMI Newborn Screening program ensures that all babies are screened for certain serious conditions at birth. For babies identified with a condition, it allows medical providers to start treatment to prevent harmful effects.

The improvements made in the CNMI Newborn Screening Program were a result of the effective partnerships between the CNMI Title V MCH Program, the CHCC Pediatrics Department Chairperson, the CHCC Laboratory Department, and the Oregon Public Health Laboratory.

MCH Title V funds are used to support the cost associated with shipping the blood specimens to the Oregon Department of Public Health Laboratory and MCH staff are assigned to monitor screening results, ensuring procurement of the needed shipping and supplies, and coordinate follow-up and referrals for treatment of babies identified through the program.

Partnership activities that took place that supported the improvement in screening rates included:

Implementing a contract with Oregon Public Health Laboratory to enable more timely shipment of newborn bloodspot supplies (cards).

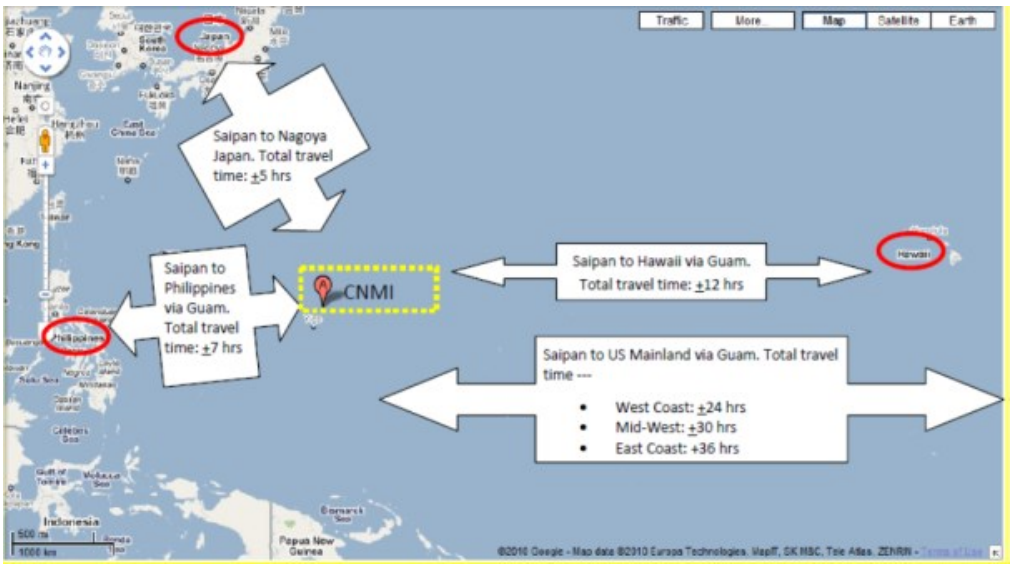
Revision of CHCC Laboratory policy to enable daily specimen collection of the hospital nursery.

Increasing shipment frequency from 3 days a week to 5 days a week.

Providing access to CHCC Laboratory and Pediatric providers to the Oregon Public Health Laboratory data system to view results.

III.B. Overview of the State

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



In October 2011, Public Law 16-51 dissolved the Department of Public Health and created the Commonwealth Healthcare Corporation (CHCC). CHCC is a quasi-governmental corporation, and while it is a part of the CNMI Government, it is semiautonomous. The CHCC is the operator of the Commonwealth's healthcare system and the primary provider of healthcare and related public health services in the CNMI. This law transferred all the functions and duties of the CNMI Department of Public Health including management of federal health related grants to the Commonwealth Healthcare Corporation, so that the CHCC is the successor agency to the now defunct Department of Public Health. The only hospital in the CNMI is also administered by CHCC. The CHCC is governed by a Board of Trustees and managed by the Chief Executive Officer (CEO) of CHCC. The CEO is the authorized representative for all federal grants, including the CNMI MCH Title V Program. On August 3, 2022, a recent review of the Commonwealth Healthcare Corporation's organizational infrastructure was conducted to better align and improve the integration of services and functions leading to the fulfillment of CHCC's overall mission. As a result, the re-organization consists of the following five domains: 1) Executive Administration, 2) Financial, 3) Medical, 4) Operations, and 5) Nursing. Under each domain there are main functional areas and/or service lines assigned with the intent to establish a unified oversight, accountability, and implementation of a system approach. In addition, the Operations domain was updated to incorporate the oversight of ancillary services, systems wide operational functions, population health, and acute care. The approach to population health was revamped and expanded as a core functional area under Operations that includes the integration of the following services: Clinical, Public Health Services and Mental Health Services, along with its assigned management accountability that all work together to improve and optimize the health of our community and therefore, population. The CNMI MCH Title V Program falls with the Population Health

Services section and administered under the oversight and direction of the Director of Public Health Services.

Demographics

2020 US Census Update for the Northern Mariana Islands

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

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

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

Source: US Census Bureau

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

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

Table 2: MCH Population in 2020

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

Source: U.S. Census Bureau

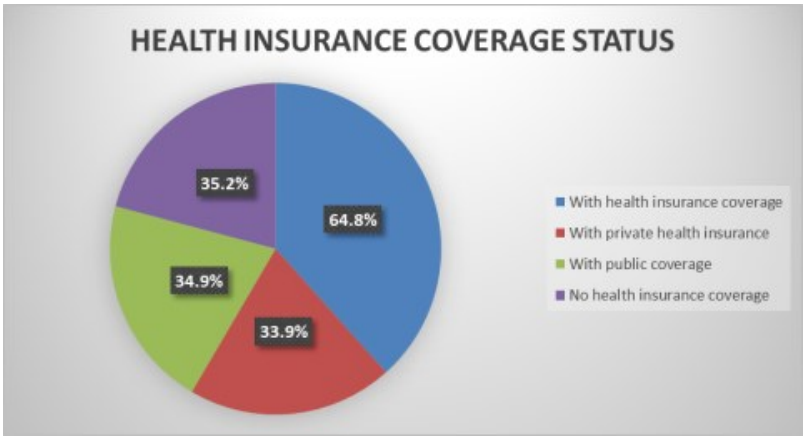
Table 3: CNMI Population by Ethnicity, 1990 – 2020.

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

Source: U.S. Census Bureau

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

Figure 1. Insurance Coverage in the CNMI- 2020 US Census



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. In 2020, the United States Government Accountability Office (GAO) published a report to US congressional committees which indicated growth in the CNMI's economy in 2016 and 2017, based on estimates of gross domestic product (GDP). However, the GAO reports a drop in GDP as a result of sharp decreases in tourist spending following severe damages to the CNMI caused by super typhoon Yutu in 2018[iv]. Real gross domestic product (GDP) for the CNMI decreased 29.7 percent in 2020 after decreasing 11.3 percent in 2019. Furthermore, the CNMI economy was substantially affected by the COVID–19 pandemic due to its effects on spending by consumers, visitors, businesses, and

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

Healthcare for the MCH Population

Commonwealth Healthcare Corporation (CHCC)

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

The Commonwealth Legislature cited a desire for the hospital to be an "independent public health care institution that is as financially self-sufficient and independent of the Commonwealth Government as is possible." Although the CHCC now exists as a quasi-independent institution, it remains a public corporation charged with the responsibility of providing essential health care to the people of the CNMI. Yet, since its inception, the CHCC has struggled with the transition from a government agency to a public corporation. And while the CHCC has made progress the past several years in expanding services and increasing access to healthcare, the large uninsured population coupled with minimal funding support from the CNMI government to address indigent care costs continues to challenge the CHCC.
By the end of 2022, the CHCC had an estimated 940 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 System is designated by the CNMI Governor as the Lead Agency for carrying out the general administration, supervision, and monitoring of the early intervention program and activities in the CNMI. Services for children with special healthcare needs age three to five years are provided through the CNMI Public School System's Early Childhood Program and for those ages five through 21 years through the Part B, Special Education Program. The following services are available for children with special healthcare needs in the CNMI: audiology services, occupational therapy, physical therapy, service coordination, sign language services, speech-language pathology services, vision services, psychological services, and counseling. According to the CNMI Public School System, 1,094 children with special needs were served. There were 76 infants and toddlers enrolled in Early Intervention Services, 84 children ages 3-5 served through early childhood special education, and 934 in the K-12 category through were served through special education[vii].
As a joint effort formalized through an Interagency Agreement, the CHCC MCH Program provides service coordination for infants and toddlers who are enrolled in Early Intervention Services. The CNMI Title V MCH Program facilitates and/or supports programs for the early identification of children from birth through five and supports referrals of children with special healthcare needs to Early Intervention services. For school year 2022- 2023, there were a total of 173 referrals made to the Early Intervention program, with 78 qualifying for services of which 60 were identified with a developmental delay and 18 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 two physicians, 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 nurses, 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.

Mobile Clinic Services

In the fall of 2022, the CHCC began offering primary and preventive health services via a mobile clinic. Prior to 2022, the last time mobile clinic services were provided on Saipan was in 2018, prior to typhoon Mankhut and Yutu. In 2020, the CHCC began the procurement process to purchase a new and larger mobile clinic unit to as part of efforts to expand access to

preventive health services and for reaching the underserved within the population. The CHCC mobile clinic serves as an extension of the outpatient clinic services available via CHCC and offers routine adult, well-woman, well child, family planning services. Community Health Workers (CHWs) were recruited to coordinate outreach services and to work with medical providers from the outpatient clinics in scheduling outreach events. The CHCC mobile clinic services the island of Saipan.

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.

Private Clinics

In addition to the CHCC clinics and the FQHCs, the CNMI has five private clinics that also provide preventive healthcare to the MCH population.

Challenges that Impact Access to Healthcare

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

Uninsured Population

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

Inter-Island Medical Referral Services

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

Off-island Referrals

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[ix]. An economic crisis that began in the year 2000 impacted both the CNMI population's ability to be able to access healthcare, more importantly, preventive healthcare and government spending, including spending on healthcare. In the year 2000, the CNMI's garment manufacturing industry began to slowly close its doors until it eventually completely phased out in 2006. In addition to this, tourism, the CNMI's second largest industry experienced a major decline. 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[x]. 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[xi].

The most current data available 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.

On January 31, 2023, Public Law 22-33 was signed into law, transitioning the Medical Referral Office from the CNMI Office of the Governor to the Commonwealth Healthcare Corporation. The Medical Referral program now operates as the Health Network Program providing airfare, housing, and transportation assistance to qualified individuals.

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.

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 Centers of Disease Control to establish a uniform system for handling records that satisfy legal requirements as well as meet statistical and research needs at local, state, and national levels.

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

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

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

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

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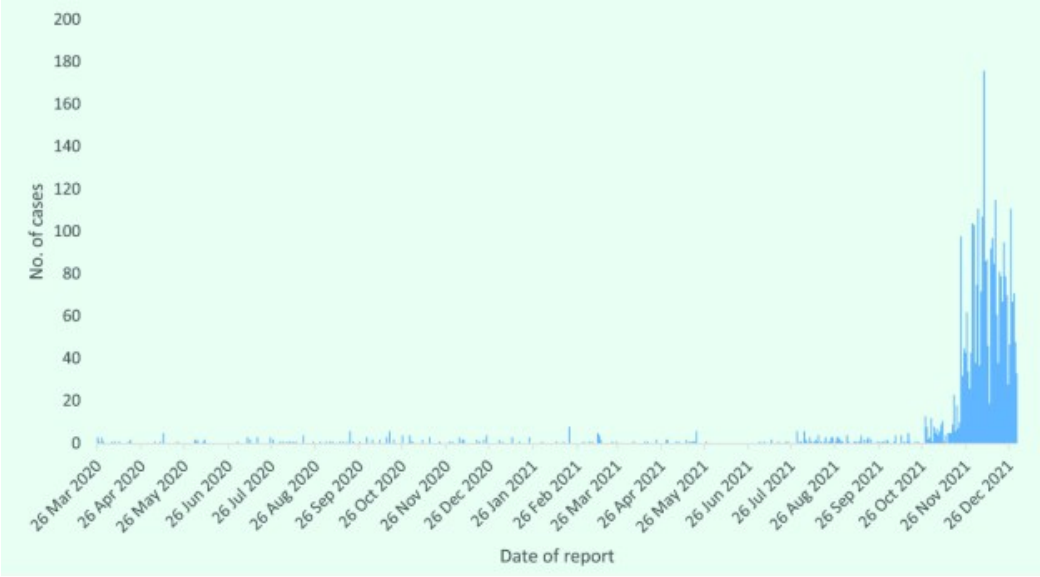
COVID-19

The first COVID-19 community cases in the CNMI were identified on March 26, 2020 with limited further transmission. After eliminating local transmission in 2020, CNMI experienced its next community outbreak, again comprising only a small cluster of cases, in March 2021. A larger, more prolonged outbreak occurred at the end of 2021, extending into 2022. Before this large outbreak, the CNMI had time to obtain adequate resources, train personnel and deliver a community-based vaccination campaign and access to treatments. Thus, by the time of the first significant community spread, CNMI was uniquely protected; the case fatality rate was low and there was sufficient capacity within the health-care system to cope with increased case numbers as a result of the importation of both the Delta and Omicron variants of concern (VOCs). Between March 2020 and October 2021, the period between the first case notification and the start of the larger community outbreak in October 2021, the CNMI recorded just 291 cases, with a vaccination coverage rate at 73.4% in the overall population and 90.4% of the vaccine-eligible population (individuals aged 12 years and older)[1]. By December 2021, just 2 months after the start of the CNMI's first surge, the COVID-19 cases reported totaled 3,281 (see Figure 1).

Figure 1. Daily number of laboratory-confirmed COVID-19 cases, Commonwealth of the Northern Mariana Islands, 26 March 2020–31 December 2021 (N = 3281)



The COVID-19 outbreak that occurred at the start of FY2022 resulted in schools transitioning to virtual learning, increased community-based testing, and increased vaccination activity to vaccinate those in the community who have not been vaccinated and young children and infants, when vaccines were made available to those populations. The CHCC worked closely with the CNMI Public School System to provide school-based vaccination services, coordinate communications to increase vaccine confidence, and monitor vaccination data to inform targeted vaccination activities and to assist with decisions on when schools will resume in person learning. Division of Public Health staff members, including MICAH team members were engaged in the overall territory response efforts, including aggressive testing, treatment, and vaccination campaigns, guided by recommendations by the US Centers for Disease Control and Prevention. A second wave, or surge, of COVID-19 infections occurred in the early part of 2022 and then a third smaller surge in the summer months (see Figure 2).

Figure 2. COVID-19 Cases Reported in the CNMI in 2022.

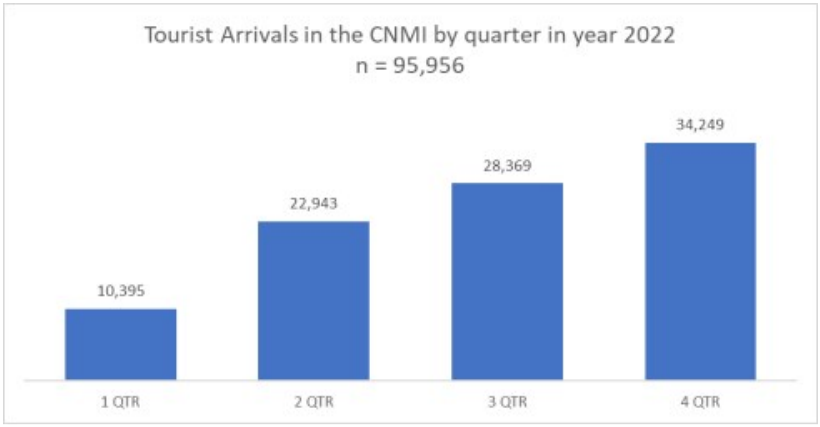
Source: Commonwealth Healthcare Corporation Weekly Syndromic Surveillance Report

In addition to schools, many community partner agencies transitioned to remote work suspending face to face activities and community events, which significantly impacted the CNMI MCH Title V workplan activities including the implementation of evidence based strategies and the collection of Evidence Based or Informed Strategy Measures (ESMs).

As of July 08, 2023, there were a total of 13,981 reported cases of COVID-19 in the CNMI, 311 hospitalizations and 46 deaths related to COVID-19. The COVID-19 fatality ratio in the CNMI is .33%, lower than the nation's rate of 1.1%.[2]

In 2020, the COVID-19 pandemic severely impacted the CNMI workforce, especially those in the tourist and service industries, which are major sources of revenue in the Northern Mariana Islands. However, in 2022, with the easing of travel restrictions and the downgrade of covid-19 pandemic, the tourist industry began showing signs of recovery with 95,956 or 656% increase in tourist arrivals from the previous year. Majority of the tourist populations that are traveling to the CNMI are from Korea, representing 78% of visitors, followed by Guam and U.S. at 10% and 7% respectively. Table 1 illustrates the tourist arrivals by quarter in the year 2022[3].

Figure 3. Number of arrivals to the CNMI in 2022



On-going Needs Assessment Activities

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

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

The MCH Jurisdictional survey is a Federally available data (FAD) source used to gather valuable MCH data to inform annual needs assessment activities as well as serving as a data source for National Outcome Measures (NOMs) and National Performance Measures (NPMs). A third round of MCH Jurisdictional survey is critical for attaining data to inform the Title V Maternal and Child Health (MCH) Block Grant annual reports. The 2021 MCH Jurisdictional survey provided data for 19 National Performance Measures and 14 National Outcome Measures for the Title V MCH Block Grant Programs.

In May 2021, the CHCC was awarded funding through the Centers for Disease Control and Prevention (CDC) to implement the Pregnancy Risk Assessment Monitoring System (PRAMS). The PRAMS collects jurisdiction-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. PRAMS surveillance currently covers about 81% of all U.S. births. The CNMI MCH will utilize the PRAMS data to investigate emerging issues and to plan and review programs and policies aimed at improving health outcomes for CNMI mothers and babies. The State Systems Development Initiative (SSDI) supports the PRAMS Integrated Data Collection System (PIDS) by using SAS software to generate monthly samples and summarize information in the dataset. Data collection from the sample birth records began in July 2022 through June 2023. For the Calendar Year 2022, the PRAMS project sampled 373 birth records of the total 473 live births recorded in the CNMI. At the end of the Phase 8 data collection, the CNMI PRAMS project accomplished a 57.91% response rate. Currently, the CDC PRAMS is working with the CNMI to submit all requirements for data weighting. When weighted data becomes available, the CNMI MCH will be able to analyze and use data to support informed decision-making pertaining to public health interventions specific to the MCH population.

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. However, review of other indicators of preventive services among women of reproductive age in 2022 illustrate slight decreases in the number of Pap Smears conducted (803 less pap smears conducted), number of family planning visits (17% decrease), and the percentage of early prenatal care among women with live births (5 percentage point decrease).

Perinatal/Infant Health

In 2022, Health and Vital Statistics reported 473 live births in the CNMI, of which 73.57 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. Additionally, 10.8 percent of infants were born with low birthweight, an increase of 2.6 percentage points from the previous year; and the percentage of infants born preterm was 12.3 percent, an increase of 3.4 percentage points from 2021. The CNMI infant mortality rate for 2022 was 12.7 per 1,000, a slight increase from 12.2 in 2021.

Child Health

The 2021, MCH-JS indicated 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 2019 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 2019 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 that they had a preventive dental visit in the 2021. This is an increase of 14.9 percentage points from the initial 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 2019 percentage of 81.2 percent and significantly lower than the US national percentage of 90.4 percent.

There was a decrease in the vaccination coverage among CNMI children ages 19 through 35 months for the combined 7-vaccine series between 2021 (70%) and 2022 (66.3%).

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. The State value for teen births among 15 to 19 years olds decreased to 9.9 per 1000 in 2022 compared to 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 96.6 percent of teens ages 13 through 17 years with at least one dose of the HPV vaccine, 98.3 percent of the same group receiving at least one dose of the meningococcal conjugate vaccine and 99.5 percent receiving at least one dose of the Tdap vaccine.
Data for the 2021 CNMI Youth Risk Behavior Survey (YRBS) was released in the spring of 2023 providing updates on a variety of youth risk behavior for middle and high school students in the CNMI. Table 1, below, provides trend data for select indicators for the years 2015 thru 2021.

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

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

-- indicates No Data

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

According to the 2021 results of Youth Risk Behavioral Survey (YRBS), adolescents in grades 9 through 12 who are obese increased from 21.6 to 23.4 percent in 2019 to 2021 respectively; similarly, adolescents who were **not** physically active at least 60 minutes per day on 5 or more days increased from 63.5 percent in 2019 to 71.8 percent in 2021. Additionally, an increase is noted in the percentage of high school teens reporting suicidal ideation, with almost 30 percent of high school student in the CNMI reporting seriously considered attempting suicide in 2021. While the CNMI is reporting a decrease in cigarette use among high school students, the number of teens currently using and daily use of electronic vapor products, or e-cigarettes, is on the rise. According to the 2021 CNMI YRBS, more than half (56.1 percent) of high school students have tried electronic vapor products, more than a quarter (26.4 percent) reported current use, and 7.8 percent reported daily use.

Children with Special Health Care Needs (CSHCN)

According to the MCH-JS, the CNMI has an estimated 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 42.0 percent[4]. Additionally, only 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, PRAMS and State System Development Initiative. In December of 2022, the MICAH Programs Administrator, who serves as the Title V Block Grant Project Director, was promoted to the role of Director of Population Health Services. In January of 2023, the former Fiscal Specialist is now serving as the MICAH Programs Administrator.

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

During the COVID-19 pandemic response in FY2021 and into FY2022, the MCH 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 Manager and CYSHCN Program Manager 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 childcare subsidies, is an additional key partner in the MCH program's work for serving children and families. MCH continues to partner with CCDF in the CNMI wide implementation of standardized developmental screening and in implementing the Quality Rating Improvement System (QRIS), which is focused on refining and improving the standards of quality for early care and education programs in the CNMI.

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

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

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

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

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

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

Operationalization of 5-Year Needs Assessment

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

5-Year Plan Changes for 2021-2025 (FY 2022)

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

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 financial 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 end of the US federal COVID-19 Public Health Emergency (PHE) was on May 11, 2023 in addition to the World Health Organization (WHO) declaring the end of the Global Pandemic in the same month. Multiple factors contributed to the end of both the PHE and the Global Pandemic, including population immunity, access to therapeutics and treatment, and a downward trend in infections and deaths. For very many in the CNMI, the end of the PHE also means and end to Medicaid coverage. In FY2022, the CNMI had approximately 24,000 (51%)[5] community members enrolled under the Medicaid Presumptive Eligibility coverage, which ended with the PHE. The loss of Medicaid coverage for thousands in the CNMI is an emerging public health issue with the potential to negatively impact access to primary and preventive care for the CNMI population, including the MCH populations.

[1] World Health Organization. (2023). How the Commonwealth of the Northern Mariana Islands stalled COVID-19 for 22 months and managed its first significant community transmission.

[2] John Hopkins Coronavirus Resource Center. (2023). Mortality Analysis. Retrieved on July 19, 2023 from https://coronavirus.jhu.edu/data/mortality

[3] CNMI Department of Commerce (2022) Economic Indicator: Visitor Arrivals. Retrieved on July 5, 2023, from: https://ver1.cnmicommerce.com/ei-visitor-arrivals/

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

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

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

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$463,450	$465,091	$465,091	$466,540
State Funds	$0	$0	$0	$0
Local Funds	$0	$0	$0	$0
Other Funds	$474,700	$517,315	$475,634	$512,582
Program Funds	$0	$0	$0	$0
SubTotal	$938,150	$982,406	$940,725	$979,122
Other Federal Funds	$2,059,790	$3,047,227	$2,660,090	$6,730,842
Total	$2,997,940	$4,029,633	$3,600,815	$7,709,964

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$466,540	$473,287	$466,540	
State Funds	$0	$0	$0	
Local Funds	$0	$0	$0	
Other Funds	$487,995	$465,967	$479,204	
Program Funds	$0	$0	$0	
SubTotal	$954,535	$939,254	$945,744	
Other Federal Funds	$10,877,895	$5,162,601	$7,930,007	
Total	$11,832,430	$6,101,855	$8,875,751	

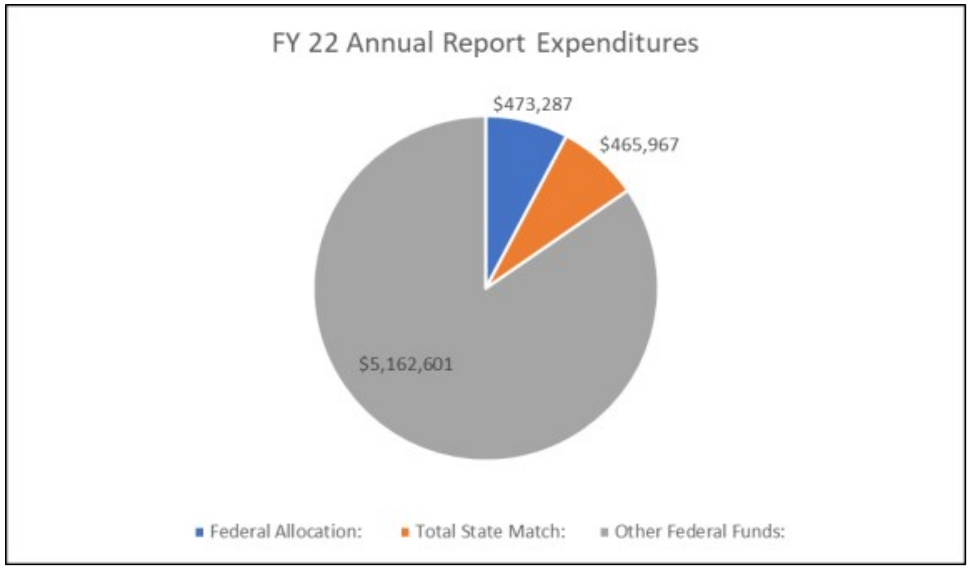
	2024	
	Budgeted	Expended
Federal Allocation	$474,000	
State Funds	$0	
Local Funds	$0	
Other Funds	$459,410	
Program Funds	$0	
SubTotal	$933,410	
Other Federal Funds	$7,401,082	
Total	$8,334,492	

III.D.1. Expenditures

Overview of Expenditures:

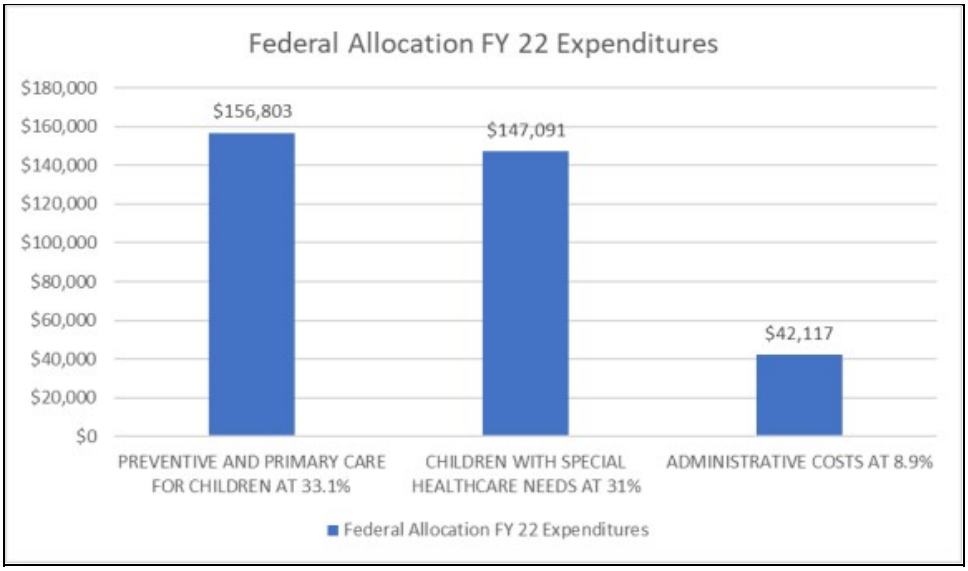
The mission of the CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and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

The chart below shows the total amount of funding expended under the MCH federal allocation, MCH state match and other federal funds during the fiscal year 2022.



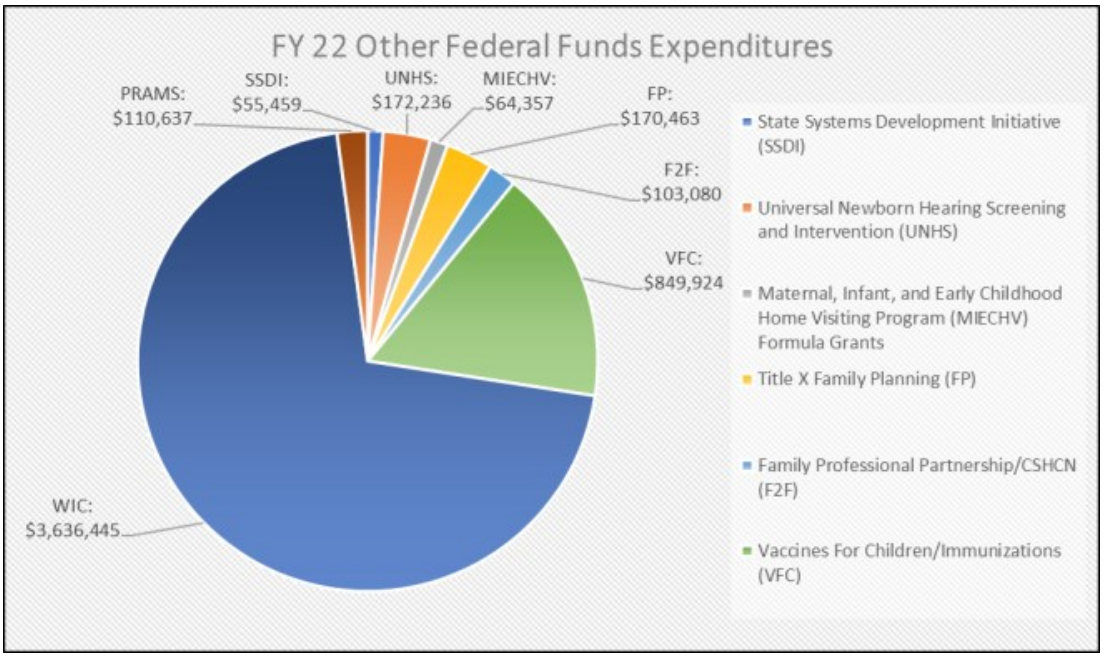
Legislative Requirements Met:

The CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. The MICAH Programs Administrator conducts monthly fund status report that consist of current funds available, funds encumbered, funds expended and the legislative required 30-30-10 percentage status report. The MICAH Programs Administrator develops the Title V Block Grant Budget and continuously monitor and track expenditures to ensure compliance with the legislative financial requirements. Expenses are monitored and tracked through the state's accounting system called the, *JD Edwards and the Tyler Technologies-Munis*. 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 22. The chart below provides an overview of the required federal allocation for the FY 22 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 Programs 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 $5,162,601 (reference chart below).



Total State Match:

The Total State Matching funds in the amount of $465,967 was expended for FY 2022. 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

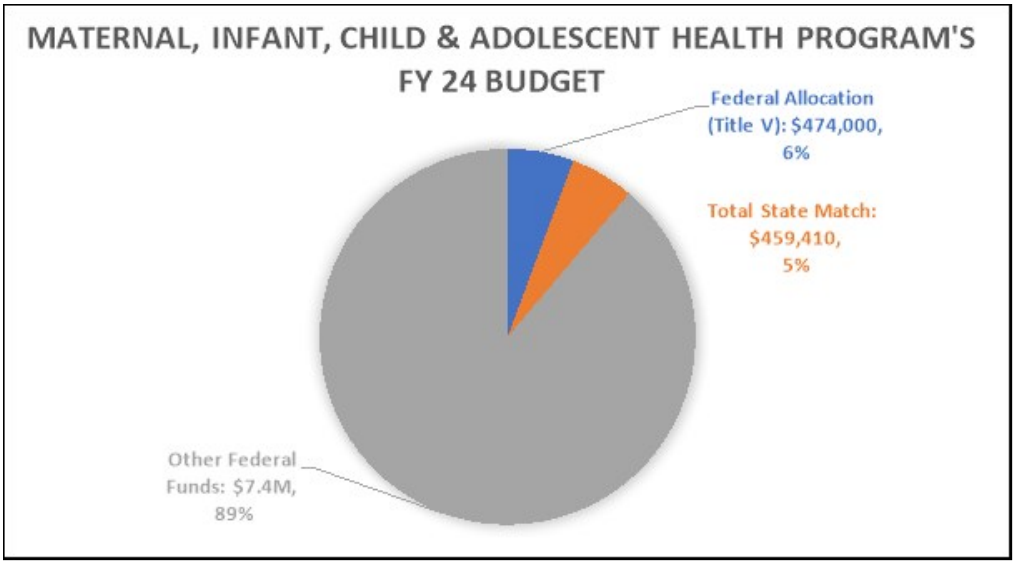
Budget Overview:

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 2024 estimating a total state MICAH Programs budget of $8.3M.

The MCH Program's State Action Work Plan has been developed based on the Needs Assessment and current emerging issues. Therefore, the MCH Program's State Action Work Plan determines where the MCH federal grant dollars are budgeted. The MCH grant, all Other Federal Funds under the MICAH Programs, and the Total State Match continues to align its overarching goals and objectives to effectively leverage resources to serve the MICAH population. The Title V funds consist of personnel salaries and fringe benefits that support the following staffing: MICAH Programs Administrator, MICAH Program Manager (Service Coordination) and 3 Community Health Outreach Workers (CHOW) I. In addition, the MCH Program cost shares with other MICAH federal program funds to support the following staffing: Adolescent & Reproductive Health Program Manager, Health Promotion Specialist, 1 CHOW I and the MICAH Administrative Specialist. The Title V funds also support 50% of the Public Health Services Director's FTE who serves as the Project Director for the MCH Title V Block Grant. The Adolescent & Reproductive Health Program Manager is funded 27% under the Title V funds and 73% under the Family Planning Program funds. The Health Promotion Specialist is funded 20% under the Title V funds and 80% under the Immunization and VFC Program funds. The CHOW I is funded 50% under the Title V funds and 50% under the Family Professional Partnership/CSHCN funds. The MICAH Administrative Specialist is funded 30% under the Title V funds and 70% under the ACA Maternal, Infant Early Childhood Home Visiting funds.

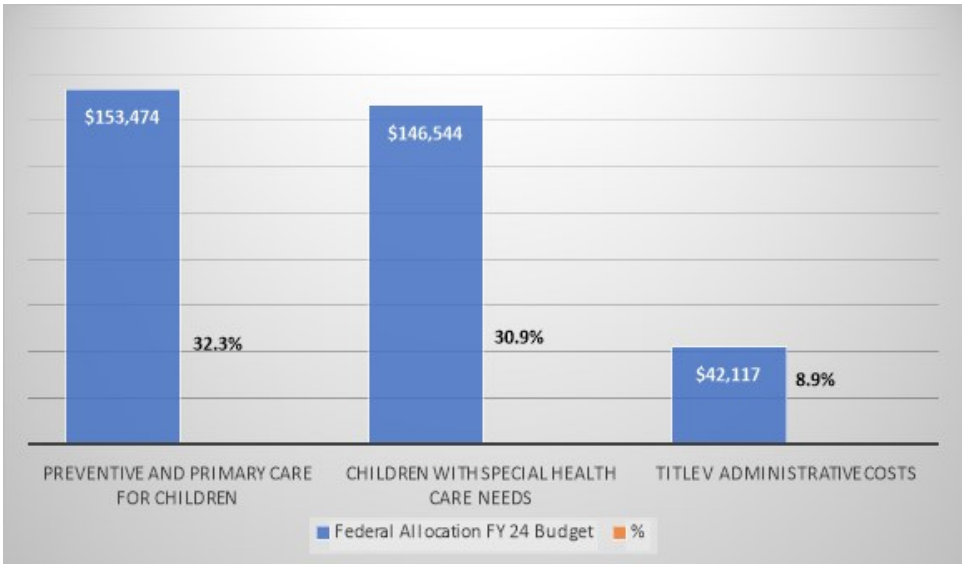
In addition to personnel salaries and fringe benefits, the Title V funds are budgeted towards Public Education and Awareness, Supplies and All Other Costs to support the MCH Programs activities and initiatives stated on the State Action Work Plan. For instance, public education and awareness costs include 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 2024 Budget as reported on Form 2.



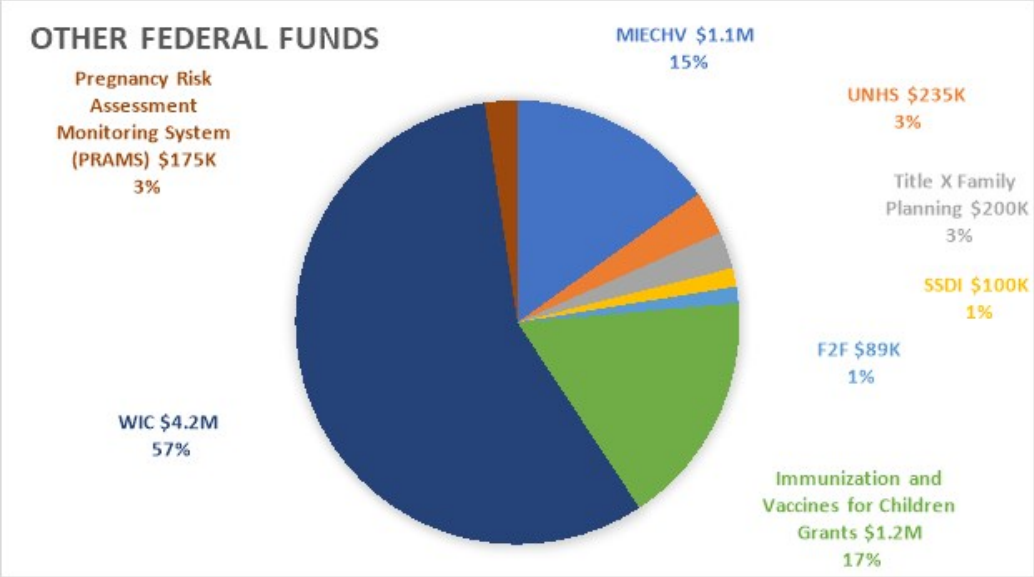
Legislative Requirements Met:

The CNMI MICAH Programs is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. One of the main duties and responsibilities of the MICAH Programs Administrator duties is to continuously ensure that the funds are being budgeted and expended per the minimum required 30-30-10 percentage. The Fiscal Year 2024 Title V Block Grant estimated budget proposal of $474,000 consist of the following types of individuals served: Pregnant Women and Infants less than 1 year of age was budgeted at $103,365 which is at 21.8% of the total federal award. Preventive and Primary Care for Children was budgeted at $153,474 which is at 32.3% 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 $146,544 which is 30.9% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Administrative costs budgeted at $42,117 which is 8.9% of the total direct costs of the federal grant award. A total of $28,500 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 24 Budget.



Other Federal Funds:

The chart below provides an overview of the Other Federal Funds budgeted that are under the direct authority of the MICAH Programs Administrator which are also listed in Form 2 [State Systems Development Initiative (SSDI), Universal Newborn Hearing Screening and Intervention Program (UNHS), Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, Title X Family Planning, Family Professional Partnership/CSHCN (F2F), 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 Programs Administrator is responsible for the administration of the Title V program budgeted for the estimated amount of $7,401,082.

Total State Match:

The MCH match is budgeted at $459,410 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 $933,410. The Total State Match funds are budgeted towards personnel salaries and fringe benefits for staff at the Commonwealth Healthcare Corporation that provides direct services to the MCH population. Since the State Match funds contribute to direct services, majority of the Title V funds contribute to enabling services and public health services and systems.

III.E. Five-Year State Action Plan

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

State: Northern Mariana Islands

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

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

The CHCC Maternal and Child Health Bureau was formed in 2014 to address the needs of the CNMI MCH population, transformation of the MCH Title V Block Grant, and link all opportunities between MCH programs to work through challenges common across programs since the transition of the Corporation into a semi-autonomous agency. Since then, the CHCC has gone through re-organization and in 2021, the MCHB was restructured under the CHCC Population Health Services (PHS) unit into the Maternal, Infant, Child and Adolescent Health (MICAH) Programs 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 FY2024.

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 Public Health Services unit is comprised of 4 sections:

- Maternal, Infant, Child & Adolescent Health (MICAH) Programs
- Non-Communicable Disease Programs
- Communicable Disease Program
- Environmental Health & Disease Prevention (EHDP)

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

Recruitment & Retention

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

and distance from the US mainland poses a challenge for recruiting medical providers and turnover is high.

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

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

Training

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

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

Web-based training opportunities provide an ideal training format for MCH staff in the CNMI, especially since many technical assistance and training needs are not easily met by local capacity. However, while virtual learning sessions provide the MCH workforce in the CNMI the opportunity to interact with experts and other technical assistance that are not readily available on island, the time difference between the CNMI and the US mainland makes it challenging for staff to participate as often times sessions are held early mornings, in some cases 3 AM CNMI time.

The need to build and improve the workforce for sustainability of the public health programs is imperative to

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

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

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

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

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

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

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

In order to ensure that services are effectively meeting the needs of the local population, programs under MICAH have taken a collective approach towards involving families in programmatic decision-making. A significant amount of family engagement activities is coordinated through the Family to Family Health Information Center (F2F HIC), a unit within the MICAH CYSHCN section. Since the implementation of the F2F HIC in the CNMI in 2019, through funds provided by HRSA and MCH Title V funding, there has been increased activity around building parent, caregiver, and family capacity around advocacy and empowerment. These were facilitated through informative learning sessions, recruitment of parent leaders to serve as peer support, parent leadership training, creating support groups such as peer matching and providing opportunities to attend in national conferences. There have been increases in participation in surveys, attending partnership meetings, participation in community awareness activities and promotion of primary care and preventive services by parent leaders in community health outreach events.

Strategies used to engage families in MCH activities in FY 2022 include:

- Hiring 3 full time Community Health Outreach Workers (CHOWs) the provide early intervention casework in Saipan, Tinian, and Rota.
- 1 full time CHOW stationed at Childrens Clinic to conduct ASQ 3 developmental screenings and hearing screenings until 3 years of age and coordinate referrals from the pediatrics department to Early Intervention Services or SPED.
- Providing stipends/vouchers to parent leaders who participate in family engagement activities, provide peer support, translation services, and other related activities
- Providing trainings and virtual learning sessions to families.
- Providing transportation assistance to families to meet their appointment needs at clinic, Early Intervention, Medicaid office and other partner agencies.
- F2F HIC parent leaders are actively promoting MICAH Programs by being in charge of the display booth at community events.
- Parent leaders are actively promoting community outreach events by tele-outreach to other parents and via Whatsapp.
- Offering flexibility in meeting hours to meet family availability (evening or weekends).

In 2022, the F2F HIC offered 6 learning sessions from May 2022 - October 2022 (*Table 1, below*). The sessions were attended by 168 individuals representing families and professionals in the CNMI. Feedback from presenters, parents, and CYSHCN serving professionals who attended these sessions indicated the sessions were very helpful in not only sharing information but in improving engagement between families and professionals who serve CSHCN. The F2F HIC is working to increase learning sessions and expand the range of topics offered to further build capacity among CSHCN families and professionals who serve CSHCN.

Table 1. Family to Family Health Information Center monthly learning sessions, 2022.

Month	Topic	Facilitator	Participants
05/2022	Supporting your Child's Mental Health	Early Head Start/Head Start Mental Health & Disabilities Coordinator, Kayla Atalig and Lead family Coordinator, Philip Santos	16
06/2022	Assistive Technology Program	Josephine Tudela, Program Manager for the Office of Vocational Rehabilitation (OVR)	45
08/2022	Promoting Healthy Lifestyles in Families and Children	Erika Vargas, MS, RD CHES, CHCC Dietary Department	27
08/2022	Parental Rights	Elsie Tilipao, Program Manager, Northern Marianas Protection & Advocacy Systems Inc.	48
09/2022	Adolescents Healthcare Transitions	Dr. Michael Do, CHCC Pediatrician	16
10/2022	Centers for Living Independently	Susan Satur, Executive Director, Centers for Living Independently	16

Currently there are 11 active parent leaders, two of which are stationed on the island of Rota, who provide peer support, outreach, and translation services for families. These parent leaders spend roughly 10 hours per month each providing these services in partnership with the F2F HIC and sign an annual agreement with the CHCC MICAH.

Additionally, monthly support group meetings are facilitated by the F2F HIC for families with children diagnosed with Autism Spectrum Disorder and another for families with children diagnosed with Down Syndrome. These monthly support group meetings are open to any family in the community seeking support or information in caring for their child. Additionally, parents who participate in these support groups take part in the annual CNMI Autism Awareness Month and Down Syndrome Awareness Month.

Support for transportation services are provided in the form of gas vouchers or COTA transportation vouchers to help families access medical or related health appointments for their children. In 2022, 60 COTA vouchers were issued for access to the following offices and locations: WIC, Children's Clinic, Dental Clinic, TB Program, radiology, behavioral health services, food stamp office, and others.

Related advisory committees that MICAH programs are involved in which include family partners as members include the: Interagency Coordinating Council (ICC), CSHCN stakeholder group, H.O.M.E. Visiting Community Advisory Board, Disabilities Network Partners, 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: Cyji C. Tenorio. Mrs. Tenorio completed college coursework at Heald College in Honolulu, Hawaii. She has an education and career background in the healthcare field, with 13 years working at a private dental clinic practice. She joined the CNMI Immunization Program in February 2023, almost 9 months after the position was vacated. The IIS Coordinator position is supported through federal funding form the Centers for Disease Control and Prevention (CDC). The IIS Coordinator is responsible for facilitating activities and project plans related to the CNMI's implementation and utilization of the immunization

registry, the Weblz. Mrs. Tenorio provides oversight of data staff, oversees the maintenance activities of the registry, monitors data quality, generates data reports and tabulations, and works with various federal, national, and regional partners such as the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), American Immunization Registry (AIRA), and others in reporting on vaccination coverage rates in the CNMI.

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

Additionally, the CNMI CHCC has been able to leverage epidemiological support from the Pacific Islands Health Officers Associations (PIHOA). During the CNMI's COVID-19 surges, where large volumes of community transmission were occurring, the CNMI was able to leverage epidemiological support from the PIHOA regional communicable disease epidemiologist, Ms. Stephanie Kern-Allely. PIHOA also provides support in non-communicable disease epidemiology to the CNMI through regional epidemiologist Dr. Haley Cash.
In the fall of 2022, the CHCC Division of Public Health entered into a Memorandum of Understanding (MOU) with PIHOA to conduct the Post- Graduate Certificate in Field Epidemiology (PGCFE) program in the CNMI. The program is formerly known as the Data for Decision Making (DDM) and made possible through the PIHOA, CDC, and Fiji National University (FNU). The program is accredited through FNU and is modeled after the Centers for Disease Control and Prevention's Field Epidemiology Training Program. The training content has been modified to meet the needs of the Pacific to identify public health challenges within the region and transform factual data into action[i].
In January of 2023, the PGCFE program launched with a cohort of 11 health department staff members of which 3 are staffers from the MICAH unit. The program is scheduled to conclude in September of 2023, where the fifth and final course module will be conducted.

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

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

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

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

COVID-19 Pandemic

Since January 2020 and throughout 2022, the SSDI staff member was periodically re-assigned to assist in the ongoing effort to manage and reduce the spread of the Covid-19 in the CNMI. The SSDI 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 Project Coordinator continues to work closely with CHCC Epidemiologist and the Epidemiology Laboratory Capacity (ELC) program for collecting Maternal, Infant Child and Adolescent health (MICAH) data including COVID-19 related data to support the interactive dashboard at the CHCC Population Health website for governmental and public use. The datasets were updated regularly and remains work in progress.

Medsphere's EHR/RCM upgrade

The CHCC's Health Information Technology (HIT) department continues to collaborate with the vendor Medsphere regarding upgrades to CareVue Electronic Health Record (EHR) and Revenue Cycle Management (RCM) system. Carevue is a centralized EHR system utilized throughout the CNMI CHCC/health department, including the Rota and Tinian sites. The system is utilized by SSDI to access information and data to inform primary and preventive care utilization analysis, types of conditions and diagnosis, and other performance and outcomes indicators collected and reported by the CNMI MCH Title V program.
Upgrades to Carevue included electronically transmitting drug prescription (eRx), Patient data object (PDO) displays patient age, weight, height, BMI and BMI percentile, and firewall security updates. 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. According to CHCC HIT, to access the Electronic Case Reporting (eCR) will not be available with CareVue EHR.

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 and second round of Maternal and Child Health Jurisdictional survey (MCH-JS-19, and MCH-JS-21) were conducted in January/February 2020; and November/December 2021 respectively. The purposes of the MCH Jurisdictional Survey are 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 similar to MCH -JS– 21; the difference included the questionnaires, sample size and survey geographical areas. For the 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 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 the first round of MCH-JS-19, the 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 are essential for meeting the federal reporting requirements and to demonstrate progress on National Performance and Outcome Measures (NPMs and NOMs), including the impact of Title V funding for improving the health and well-being of women and children in the CNMI. Table 1 illustrates a comparison of key factors identified in MCH-JS-19 and MCH-JS – 21 and identifies the improvement status of the various elements in reporting of MCH indicators that the SSDI project is working diligently to improve. For example, there have been improvements in the number of sites and sample sizes in the 2021 survey as compared to the 2019 survey, with Tinian and Rota included and the increase of 50 in sample size.

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

Table 1

Summry of Survey Key Factors	MCHJ - 19	MCHJ -21	Status
Enuerator Sites	Saipan	Saipan, Tinian and Rota	Improved
Targeted Sample Size	200	250	Improved
Total # of Indicators (NOMs and NPMs)	33	33	Same
# of NOM Measures	14	14	Same
# of NPM Measures	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 Indicator 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 NPMs with Indicator 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. CNMI MCH Title V Work Plan

Priority Need	NPM/SPM	Objectives	Strategies	Activities	ESMs	DEFINITION
Women/Maternal Health						
Access to health services- ability to find and see a doctor when needed.	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 by 10% from baseline.	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 = Percent Numerator: Number of women ages 18-44 years accessing preventive health services during CHCC clinics extended hours and/or outreach events.
Perinatal/Infant Health						
Education and support to help with 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 44%.	Implement workplace breastfeeding policies/support	1. Expand workplace breastfeeding support. 2. Conduct community awareness regarding the importance of breastfeeding for infant health. 3. Support breastfeeding supplies for families accessing hospital and clinic services.	ESM 4.1 - Percentage of infants who were breastfed at 6 months	Measure = Percent Numerator: Number of infants who were 6 months breastfed. Denominator: Total number of infants in the WIC program.
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 75%, an increase from the baseline percentage of 55%.	Provide service navigation for prenatal women	1. Service coordination for prenatal patients (support to address access challenges, i.e. uninsured assistance, transportation vouchers, etc.) 2. Expand partnerships with the WIC and Family Planning clinics to increase early prenatal care rates.		Measure = Percent 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 percentage of 53%.	Enhance partnerships with CNMI youth serving agencies or organization to provide more opportunities for physical activity among children 6 through 11 years.	1. 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. 2. 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 by MCH who reported completing at least 75% of the EFNEP program curriculum.	Measure = Percent Numerator: Number of referrals who reported completing at least 75% of the EFNEP program curriculum. Denominator: Total Number of referrals to the EFNEP program.
Adolescent Health						
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 the baseline of 42%.	Partner with the Public School System to increase the number of adolescents accessing adolescent health	Work with pediatric providers to implement evidence based behavioral health screenings during teen wellness visits	ESM 10.1 - Percentage of adolescents accessing preventive care through referrals from the Public School System (PSS)	Measure = Percent Numerator: Number adolescent who were referred by Public School System for preventive care visit Denominator Number adolescent who access preventive care visit
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 to prepare for the transition to adult health care	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	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.	ESM 12.1 - Percentage of students and/or parents who indicate increased knowledge about the importance of transition after presentations.	Measure = Percent 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
Children with Special Health Care Needs (CSHCN)						
Helping parents/caregivers navigate the healthcare system	NPM 11 - Percent of CSHCN ages 0 through 17 years 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	ESM 11.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.	Measure = Percent 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
Cross-Cutting/Systems Building						
Professionals have the knowledge and information to address the needs of maternal and child health populations	SPM 2 - Percentage of CHCC Population Health Services (PHS) staff who complete training on MCH priorities and related topics.	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.	Provide training to CHCC staff and other MCH serving professionals.	Implement a learning management system to provide training and capture completion rates.		Measure = Percent Numerator: Number of CHCC PHS staff who completed training on MCH priorities and related topics. Denominator: Number of CHCC PHS staff

CNMI SSDI Project Plan December 2022 – November 2027

In August of 2022, the CNMI MICAH Programs submitted an application for and successfully obtained funding to support the CNMI SSDI efforts through 2027. Updates to the CNMI SSDI's activities are included in the summary of the project work plan below:

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

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

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

programmatic information

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

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

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

Activity 1.5 – Coordinate the Comprehensive MCH 5-year needs SSDI Project Coordinator MICAH Administrator December 01, 2023- continuous Priorities identified and adjusted as needed based on information assessment and interim annual needs assessment updates.

Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability

Objective - By November 30, 2027, there will be an increase of 6 percent, from FY 2020 baseline of 36 NOMs with data sources, to 38 NOMs with data sources used to inform the Title V MCH Block Grant Application/Annual Report.

Activities 2.1 - Collaborate with Program Managers and Stakeholders for developing and selecting data collection tools to address gaps for reporting on all MCH performance and outcome indicators

Activity 2.2 – Update/strengthen a datasharing agreement/MOU with CNMI Public School System (PSS)

Activity 2.3 - Develop data sharing agreement with Northern Marianas College.

Activity 2.4 - Coordinate with HIT and Medsphere for data extraction training.

Goal 3: Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming

Objective - By November 30, 2027, the CNMI MCH Program will report on the use of at least 3 health equity metrics or SDoH metrics for identifying improvement opportunities and tracking the CNMI's progress as part of the Title V MCH Block Grant Application/Annual Report. Baseline data is not available.

Activity 3.1 – Convene a workgroup consisting of a diverse group of Health System representatives and community stakeholders to identify priority health equity metrics to track and inform progress on the MCH Title V Block Grant.

Activity 3.2 – Develop a data collection and monitoring plan to identify data sources, collection, and reporting timeframe for identified health equity metrics

Activity 3.3 - Develop data linkage of key MCH data sources with public health databases to track health equity metrics including race, ethnicity, income, gender, and geographic locations to reduce or eliminate health disparities and improve access to health.

Goal 4: Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19

Objective: Electronic Case Reporting (eCR) for more accurate Public Health reporting: By November 2023, and annually through November 30, 2027, the SSDI project will work to implement electronic case reporting (eCR) for improving the timeliness, accuracy and completeness of data to inform surveillance systems, prevent or contain outbreaks, and implement evidence-base intervention to protect population health.

Activity 4.1 - Coordinate with CHCC Health Information Technology (HIT) department, Electronic Case Reporting (eCR) team and Medsphere to discuss options for implementing eCR.

Activity 4.2 - Conduct audits of all MCH data sources, define standards for data formats to improve data linkages, and standardize existing data between all MCH data sources.

Activity 4.3 - Collaborate with Data Governance Council to assist in creating a data repository for all public health programs.

Activity 4.4 – Establish a Maternal & Child Health Data Dashboard to include Health Equity metrics.

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

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

Pregnancy Risk Assessment Surveillance Monitoring System (PRAMS):
Commonwealth of the Northern Mariana Islands Pregnancy Risk Assessment Monitoring System (CNMI PRAMS) is a joint research project between the Commonwealth Healthcare Corporation (CHCC) and the Centers for Disease Control and Prevention (CDC). In 2021, the CNMI PRAMS project initiated a planning and preparation phase that involved the hiring of project staff, convening of a PRAMS Steering Committee, finalization of the PRAMS research protocol, and obtaining institutional research board (IRB) approval for the project. The CNMI PRAMS is a population-based surveillance system designed to identify maternal attitudes and experiences before, during and after pregnancy. Research indicates that maternal behaviors during pregnancy impact infant birthweight, gestation and mortality rates.
The goal of PRAMS is to improve the health of mothers and infants by reducing adverse outcomes, and promoting maternal health by influencing programs, policies, and maternal behaviors. CNMI PRAMS data will be used to establish an evidence base surveillance system for data-driven public health decision making and program development.
The objectives to meet the overall goal of PRAMS are to:
• Document estimates and trends in maternal and infant indicators
• Identify subpopulations at greatest risk for the adverse birth outcomes and inform prevention strategies
• Inform the HRSA Title V needs assessment process to aid the CNMI in planning for and allocating MCH block grant funds
• Develop programs and system changes that support improvement of maternal and infant health
• Investigate emerging issues in maternal and infant health, and monitor mortality and morbidity trends for the target populations
• Support health professionals to incorporate the latest research findings into their standards of practice
• Build state capacity by serving as a significant resource for data to promote and improve the healthcare system and inform programs and policies

Upon receiving approval from the CDC IRB, the CNMI PRAMS initiated the first batch for data collection in July 2022. Both traditional methods of mailing and phone are used to collect data from live birth samples. Data from the 2022 CNMI PRAMS will be ready for analysis in the fall of 2023.
CareVue Electronic Health Record (EHR) System: The CHCC transitioned into a new EHR system in November 2021. The Carevue EHR system implementation includes the following public health reporting interphases:

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

These interphases are currently ongoing with Medsphere's CareVue electronic health record. This upgrade is intended to improve the capturing and reporting of patient data and interoperability or linkages with other healthcare data systems. This project is being directed by the CHCC Health Information Technology (HIT) Department.
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, CHCC HIT, 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. This work is on-going through 2022.

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

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

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

Early Hearing Detection and Intervention (EHDI) System linkage: Updates to the newborn hearing screening data system was completed in 2020; the EHDI program completed its data linkage interphase with CHCC Heath and Vital Statistics EVRS database.

Table 1. CNMI MCH Data Sources

Data source	Periodicity	Electronic Form	Llink to Vital Records	Information Gathered
HVSO BIRTH	QUARTERLY	YES		Birth rate, preterm births, pernatal, maternal morbidity and
HVSO DEATH	ANNUALLY	YES	YES	mortality, fetal and infant deaths, birth weights congenital anomalies, birth outcome
MEDICAID	MONTHLY		NO	Number of pregnant women and children enrolled
WIC	ANNUALLY	YES	NO	Breastfeeding rates, early childhood BMI data, Anemia screening
HEALTH OUTCOME FOR MATERNAL AND EARLY CHILDHOOD (H.O.M.E.) VISITING PROGRAM	SEMI-ANNUAL	YES	NO	Breastfeeding rates, Safe sleep practices, 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	NO	Number of women enrolled in the PRAMS Program
CHCC DENTAL/ORAL HEALTH PROGRAM	ANNUALLY	YES	NO	Rates of dental caries, preventive dental visits, prenatal preventive dental visits, oral cancer screening
DEVELOPMENTAL SCREENING	MONTHLY	YES	NO	Number of children ages 6-60 months who received ASQ screening
BREAST & CERVICAL CANCER SCREENING PROGRAM	ANNUALLY	YES	NO	Breast and Cervical Cancer screening rates
CNMI CANCER REGISTRY	ANNUALLY	YES	NO	Cancer Diagnosis Rates
IMMUNIZATION WEBIZ	DAILY	YES	NO	Childhood Immunization Rates
EARLY INTERVENTION	ANNUALLY	YES	NO	Number of CSHCN 0-3 year enrollment rate
SPECIAL EDUCTION	ANNUALLY	YES	NO	Number of CSHCN 3-21 years enrollemt rate
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,

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

Northern Mariana Islands Emergency Management Structure

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

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

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

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

Public Health/Hospital Emergency Preparedness Program: The CHCC 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 the Division of Public Health Services have been trained and served on emergency management leadership and support roles before and during the pandemic as part of the CHCC AOC.

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

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

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

These activities were scheduled to be completed in FY2022, however, as a result of the CNMI's first and subsequent waves of COVID-19 surges, they were delayed and scheduled for completion in FY2023 -2024.

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.

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

Newborn Metabolic Screening- staff worked closely with the CNMI hospital nursery department, pediatricians and the CHCC laboratory to ensure that specimen collection prior to discharge for babies born. Staff monitored screening results to

ensure that follow-up services were initiated timely to minimize risk for loss to follow-up. Additionally, what use to be a limited weekly window for collecting specimens at the nursery ward was modified to enable a 7-day specimen collection to further reduce the risk for loss to follow-up of babies born outside the specimen collection window.

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

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

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

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

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

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

Group Prenatal Care Group prenatal visits were suspended due to COVID-19 pandemic restrictions and social distancing requirements that made it difficult to coordinate face to face visits for groups of 8 to 10 women and their partners. Access to equipment and internet connection were challenges identified and made it difficult for group prenatal care to successfully transition to virtual sessions. Additionally, a virtual platform made it impossible for screenings and measurements to be conducted. Planning to resume group prenatal sessions occurred in FY2022.

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. The data collected during the initial year of the CNMI PRAMS will be available to the CNMI for analysis by the fall of 2023 and results included in the next annual MCH Title V Block Grant report submission.

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

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

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

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

The MCH Title V Program is administered under the CHCC Maternal, Infant, Child and Adolescent Health (MICAH) 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.

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

- 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.

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

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

- 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.

- Kagman Isla Community Health (KICH) & Tinian Isla Community Health Centers (TICH)
  - The KICH and TICH are Federally Qualified Health Centers (FQHC) located on the islands of Saipan and Tinian, respectively. The CHCC Division of Public Health MICAH Programs partners with the CNMI FQHCs in efforts to expand vaccination coverage to ensure access to vaccines for the CNMI pediatric population. This partnership includes:
    - Access to CDC funded vaccines for uninsured or underinsured children and adults, including pregnant women.
    - Training on vaccine storage and handling
    - Patient education/informational materials
  - Additionally, the Medical Director for Public Health and Title V MCH Director met with the FQHC Medical Director to provide an overview and presentation on programs and services available through the CHCC Division of Public Health, including MICAH programs, to the population served by the FQHC. Technical assistance on developmental screening and access to transportation vouchers for pediatric visits were among the MCH related services discussed during the meeting.

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

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

- Disability Network Partners (DNP): The Disability Network Partners (DNP) is a collaborated effort between CNMI Government Agencies 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.

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

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[i].

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 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 (77.4%) Medicaid program enrollees, out of a total estimated population size of 47,329[ii]. Medicaid Presumptive Eligibility had been extended in alignment with the Public Health Emergency (PHE) and ended when the PHE expired. According a report by the CNMI Medicaid Agency, the total number of Medicaid members served in FY2022 was estimated at 47,000 with approximately 24,000, 51 percent of the total population, of that total being beneficiaries of Presumptive Eligibility coverage[iii].

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.

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[i] Commonwealth Medicaid Agency. (2021). 2021 Citizen-Centric Report. Retrieved on July 27, 2022 from CMA-FY-2021-CCR.pdf (opacnmi.com)
[ii] 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] Commonwealth Medicaid Agency. (2022). 2022 Citizen Centric Report. Retrieve on July 17, 2023 from https://www.opacnmi.com/oockuvoa/2022/12/Commonwealth-Medicaid-Agency-FY-2022-CCR.pdf

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

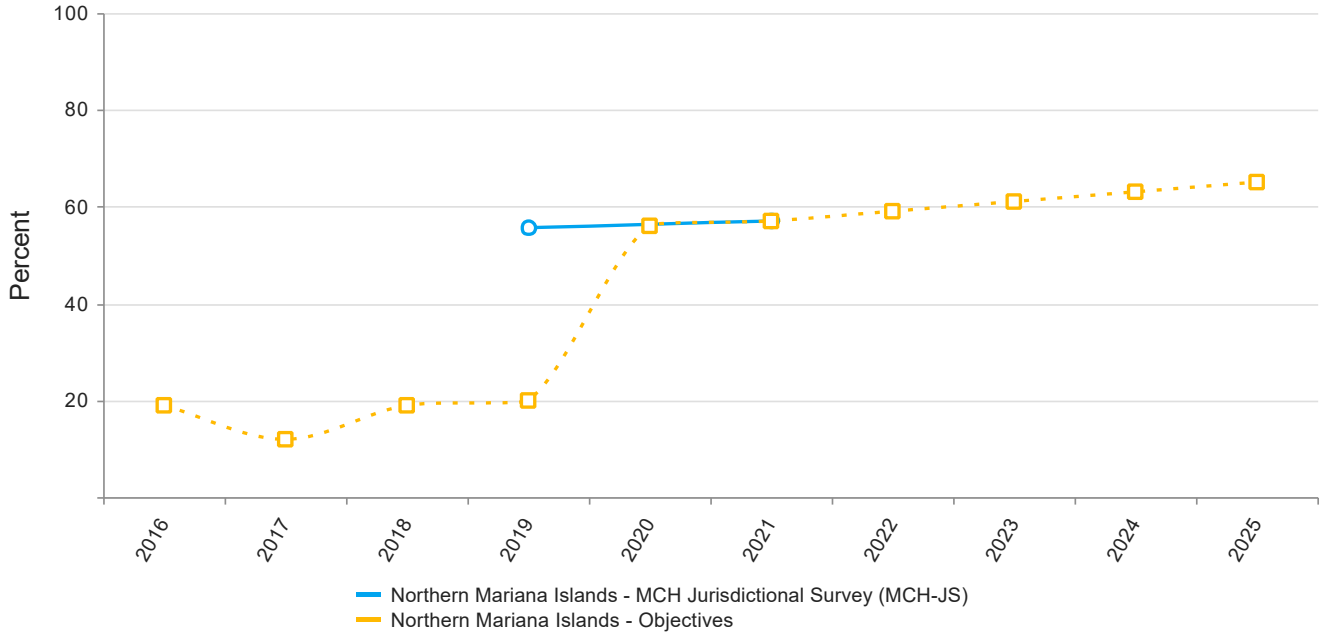
State Action Plan Introduction

As part of the MCH Title V Program, the CNMI developed a five-year State Action Plan to address the priority needs for the CNMI's MCH population. The plan presented in this year's submission outlines both the planned activities for the upcoming FY2024 as well as a report on activities that were completed in the reporting year, FY2022. 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**	**2022**
Annual Objective		56	59	59
Annual Indicator	55.5	55.5	57.1	57.1
Numerator	6,544	6,544	7,415	7,415
Denominator	11,784	11,784	12,993	12,993
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	19	20	56	57	59
Annual Indicator	20.5	22.7	25.4	65.4	
Numerator	1,587	1,757	1,959	5,047	
Denominator	7,732	7,742	7,721	7,717	
Data Source	CNMI EHR Pap Exam, International database estimate	CNMI EHR Pap Exam, International database estimate	CHCC Preventive Visits and US international census	CHCC EHR/RPMS Preventive visits	
Data Source Year	2018	2019	2020	2021	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	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 all CHCC health service sites.

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	53.0	55.0	57.0

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. Conduct community awareness activities to promote women's preventive health visits.	
ESMs	**Status**
ESM 1.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.	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 FY2022, the MICAH programs through the MCH Services Manager, continued to provide support to pregnant clients and children for expedited processing of Presumptive Eligibility for Medicaid application 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 continued collaboration and partnership with the CNMI Women's Clinic department, an office for MCH services continue to be dedicated 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.

Although there were changes and some easing of restrictions in FY2022, the COVID-19 Public Health Emergency continued to pose a challenge for MCH block grant activities and strategies identified in the MCH work plan to be fully implemented. Nurses, providers, and Public Health staff continued to involved in response work and supporting testing, vaccinations, treatment, and risk communication efforts.

The priority identified through the 2020 comprehensive MCH needs assessment process for women's health in the CNMI was "Access to health services- ability to find and see a doctor when needed." This priority is aligned with the national performance measure (NPM) 1, percent of women ages 18 through 44 years with an annual preventive visit. The data source that informs the NPM 1 is the MCH jurisdictional survey, which was conducted initially in 2019 and then updated in 2021.

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	2022
Percent	55.5	57.1	57.1
Numerator	6,544	7,415	7,415
Denominator	11,784	12,993	12,993

Source: MCH Jurisdictional Survey

Based on the MCH Jurisdictional Survey conducted in 2019, in 2020, 55.5 percent of women ages 18 through 44 years reported an annual visit. In 2021, a second round of survey was conducted and indicated slight increase in this measure to 57.1 percent. The 2021 data is used for the 2022 reporting year.

Strategy: Expand preventive healthcare: Increase clinic hours

In FY2022, the MICAH programs, through its SSDI project, conducted an online survey as part of its efforts for evaluating community access to women's preventive health services. With support from an intern through the AMCHP Graduate Student Epidemiology Program (GSEP), the MICAH programs was able to develop an online survey to gather information to inform activities around NPM 1 and further understanding regarding access to preventive healthcare among women in the CNMI. A total of 300 surveys were completed with 73 percent of respondents being women ages 18 through 44 years. Based on the information gathered through the survey, respondents reported that long waiting lists and other challenges with scheduling an appointment as a top challenge for accessing healthcare.

The acquisition of the mobile clinic is crucial to expand the services to the target population. Utilizing this newly acquired mobile clinic unit was a strategy intended to expand hours and accessibility to women's preventive healthcare in the CNMI. However, in FY2022, due to delays in the production and shipment of the mobile clinic caused by the global COVID-19 pandemic, the implementation of outreach services did not materialize. However, staff supported by the MCH Title V Block Grant did work collaboratively with the CHCC Outpatient Clinics to develop policies, standard operating procedures, and develop a schedule for outreach to implement at the start of FY2023.

Additionally, other work to expand preventive healthcare access for women in the CNMI included women's health services on the island of Rota. In FY2022, working in partnership with the CNMI Breast and Cervical Cancer Screening Program (BCSP), MCH Title V was able to support monthly Women's Health Clinic outreach to the island of Rota to provide services such as Well-Woman Visits, prenatal care, and family planning.

Despite the challenges with covid, 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.

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

Year	2021	2022
% Served	65.4	53.1
Numerator	5047	4057
Denominator	7717	7641

In 2021, the MICAH programs began data collection utilizing the CHCC health system's centralized electronic health record (EHR) system to inform ESM 1.2: Percent of women who report accessing preventive health services at the CHCC including areas like the Family Planning and Mobile Clinic areas. Utilizing ICD-10 codes, provider narrative, and chief complaint or purpose of visit (POV) fields available in the EHR, the program was able to identify the number of women accessing preventive health services through all CHCC sites, including locations on the islands of Tinian and Rota. The denominator value is based on the population estimate available through the US Census International database of women in the Northern Mariana Islands ages 18 through 44 years and the numerator is based on the number of women of the same age range accessing preventive health services at the CHCC health system. In 2021, 65.4 percent of the target population accessed preventive health services at the CHCC and in 2022 the percentage was 53.1 percent. The MICAH programs objective for this is ESM is for an increase to 57 percent in the year 2025.

In addition, the MICAH programs look at preventive health utilization accessed by the women/maternal population via the CNMI Family Planning Program (table below).

Percentage of females age 18 – 44 years served by the CNMI Family Planning Program, 2016 – 2022

Year	2016	2017	2018	2019	2020	2021	2022
% Served	11.7	11.6	14.6	16.3	15.1	16.1	13.14
Numerator	953	921	1127	1262	1164	1241	1,004
Denominator	8114	7895	7732	7742	7721	7717	7641

Data Source: CNMI Family Planning Annual Report

The Family Planning Annual Report (FPAR) is published annually to outline the reach of the program within the CNMI community and is used to inform analysis conducted by the MICAH programs regarding utilization of preventive health services. The Family Planning program is a key component for providing access to preventive health services within the women population in the CNMI. In 2022, the program served a total of 1,004 (13.4%) unduplicated number of women ages 18 through 44 years in the CNMI. The numerator value for this measure is gathered through program encounter data while the denominator is based on population projections made available by the US Census International Database. The report indicates a slight decrease in the number and percentage of women served. Similar to other Public Health activities and services within the CNMI, the COVID-19 pandemic and the CNMI's first large surge of COVID-19 infections that occurred in FY2022 significantly impacted efforts towards improving the number of women served.

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

Number of Pap Tests Conducted in the CNMI, 2016 – 2022

CNMI PAP Data	2016	2017	2018	2019	2020	2021	2022
Number of Tests	**1,669**	**1,425**	**1,437**	**1,516**	**1,895**	**2,682**	**1,879**

Data Source: DLS Hawaii

In 2022, a total of 1,879 pap tests were processed by the DLS in Honolulu. There was a decrease of 803 pap tests conducted in 2022 compared to the year prior. However, it is important to note that the average number of pap tests conducted in the most recent 3 years (2020 – 2022) is 2,159 compared to the average of the prior 3 years (2017 – 2019) at 1,459. The difference between the 2020 – 2022 and 2017 – 2019 timeframe reflects a 47.9 percent increase in the number of pap smears conducted since the implementation of presumptive eligibility for Medicaid, which happened in 2020.

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 2022. CNMI Women's Health Month is celebrated during the month of May each year. In 2022, there were a total of 23 social media posts during CNMI Women's Health Month with a total "reach" of

29,932, 523 “likes & reactions” and 99 content “shares”. Due to efforts to address the CNMI’s first significant surge of COVID-19 infections in 2022, other community awareness activities, such as newspaper advertisements, radio ads, and presentations were impacted and postponed till the FY2023.

Women/Maternal Health - Application Year

Throughout the needs assessment process, women's health consistently was voiced as a priority and it became apparent that the recurring themes in this domain reflected the overall needs of the CNMI. As a result of the 2020 comprehensive MCH Needs Assessment process, Priority 1 under the Women's Health domain was identified as "Access to health services- ability to find and see a doctor when needed." CHCC MICAH Programs have existing successful partnerships, resources and services and at an adequate position to provide more and engage community partners, build on existing programs, and address the needs of the state's woman/maternal population. The following actions are addressed in this priority: uniform screening, coordinated care, increased access to care through extended hours and additional locations, increased well woman visits, and understanding of preventive health coverage.

Activities to address priority areas identified during the 2020 comprehensive needs assessment for the Women/Maternal Health domain will continue to be guided by the life course framework. The MCH program will work in partnership with clinical providers and partners to ensure activities to address this priority are implemented on the islands of Saipan, Tinian, and Rota.

In FY2023, the newly acquired CHCC Mobile Clinic was implemented and focused on increasing access to primary and preventive care services including well woman visits, prenatal care and Family Planning.

Priority Need 1 is linked to National Performance Measure (NPM) 1, in which annual reporting on the percentage of women ages 18 through 44 years who access preventive medical visits will be conducted. The objective for Priority Need 1 and NPM 1 is to increase the percentage of women accessing preventive visits to 65 percent by 2025. Data to inform this domain will be gathered from the MCH jurisdictional survey as well as other programs and services that serve the women population through the CHCC.

Priority Need 1: Ability to find and see a doctor when needed (access to health services)

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

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

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

For FY2024, the CNMI MCH Title V will further expand its partnership with the CHCC Outpatient Clinics department to increase women's health primary and preventive care access via the mobile clinic and will also continue to support monthly women's health clinics on the island of Rota. In FY2023, the MICAH programs began offering Saturday Family Planning clinics out of the Immunization clinic located within the Division of Public Health clinic areas. The pilot Saturday Family Planning clinics will be evaluated to determine impact of the additional hours in expanding access to preventive services. The evaluation results will further guide improvements or change strategies that will be implemented to further improve access to care.

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

Evidence Based Strategy Measure (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 CareVue. The program will assess the number and percentage increase in service utilization on a monthly basis among women/maternal population seen through the following CHCC clinic locations: Women's Clinic, Mobile Clinic, Family Planning Clinics, Rota Health Center, and Tinian Health Center.

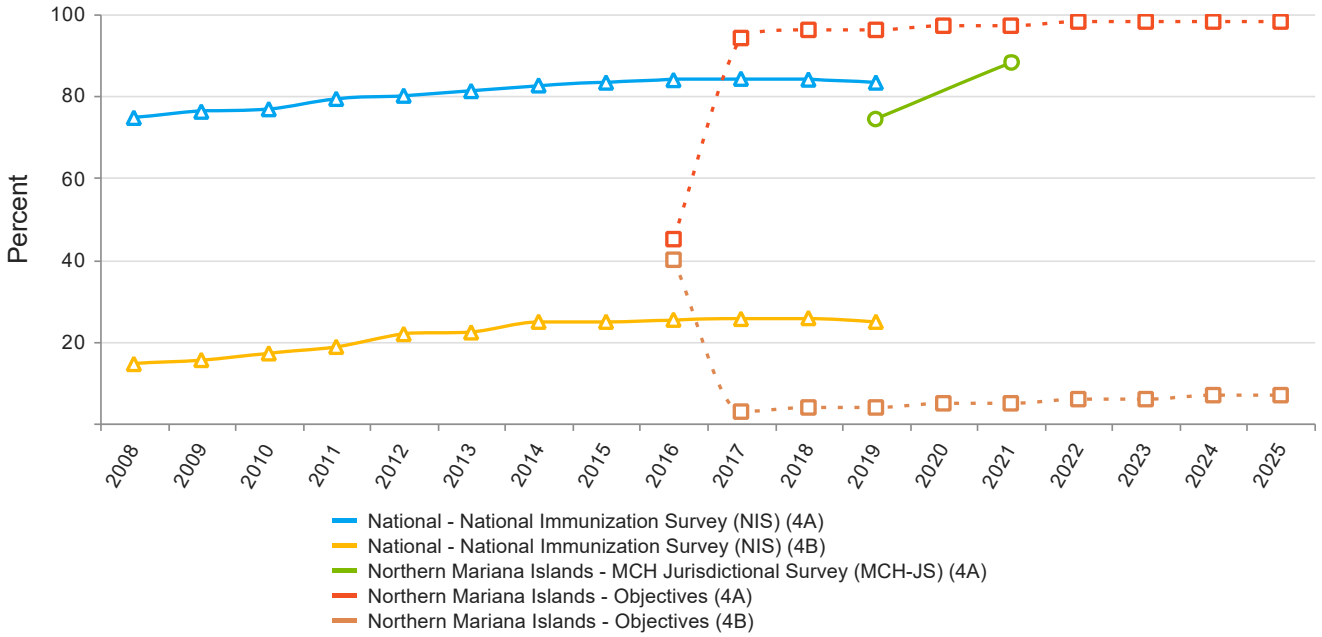
Strategy: Provide community awareness regarding women's preventive health services.

Community awareness activities will continue to be a vital component to activities conducted by the CHCC MICAH programs. The MCH Program will work with the Communications and Marketing Specialist to develop communications and advertising materials to effectively informed the community regarding available services, service sites, and hours. MICAH will reach out and connect with external partners: government and private businesses, private insurance companies and different faith-based communities and non-profit organizations as a leverage to disseminate scheduled outreach events information to their clients and members of their communities as part of efforts encourage them in accessing services.

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**	**2022**
Annual Objective	96	97	98	98
Annual Indicator	74.2	74.2	88.2	88.2
Numerator	4,288	4,288	5,434	5,434
Denominator	5,776	5,776	6,158	6,158
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	96	96	97	97	98
Annual Indicator	95.8	96.5	93.3	93.7	94.9
Numerator	1,209	877	610	539	449
Denominator	1,262	909	654	575	473
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	2018	2019	2020	2021	20
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	4	4	5	5	6
Annual Indicator	2.5	1.1	0.4	0	0.5
Numerator	12	5	2	0	2
Denominator	486	470	544	419	411
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6.0	7.0	7.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	57.4
Annual Indicator			44.6	39.9
Numerator			187	164
Denominator			419	411
Data Source			WIC Program	WIC Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	47	49	51	53	70
Annual Indicator	48.3	48.8	55.6	66.8	61.7
Numerator	329	340	351	382	290
Denominator	681	697	631	572	470
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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 WIC 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 premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care

SPM

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

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 2022 (October 01, 2021 through September 30, 2022). 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.

In FY2022, activities planned to address the CNMI MCH priority education and support for breastfeeding and improving early prenatal care were impacted by the COVID-19 pandemic.

The following report provides an overview and details on the NPMs and SPMs along with information on the activities that were completed in FY2022 to address the priorities of breastfeeding and early prenatal care as part of the infant health domain.

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

Breastfeeding	2016	2017	2018	2019	2020	2021	2022
Percent of Infants	95.5	94.7	95.8	96.5	93.3	93.7	94.9
Numerator	1,162	1,145	1,209	877	610	539	449
Denominator	1,217	1,209	1,262	909	654	575	473

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 2022, 94.9 percent of live births were breastfed. The breastfeeding rate slightly increased from the year prior.

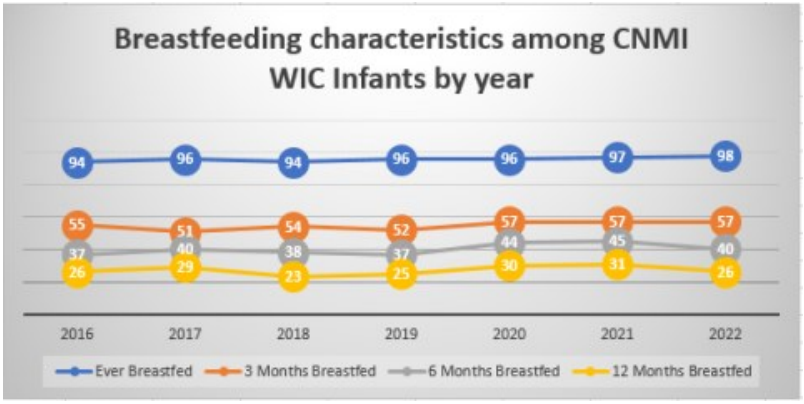
NPM 4B: Percent of infants breastfed exclusively through 6 months.

Exclusive Breastfeeding	2016	2017	2018	2019	2020	2021	2022
Percent of Infants	1.7	2.5	2.5	1.1	.4	0	.5
Numerator	9	13	12	5	2	0	2
Denominator	535	518	486	470	544	419	411

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 2022, there were 2 infants who met the criteria for breastfeeding exclusively through 6 months of age.

Figure 1. Breastfeeding Rates among CNMI WC infants, 2016 through 2022



Source: CNMI WIC Program

While breastfeeding initiation rates in the CNMI of 94.9 percent is higher than US national rate of 83.2 percent[i], its 6 months breastfeeding rate (40 percent) trails behind the US average of 55.8 percent. A review of breastfeeding data from the CNMI WIC program from the past 5 years illustrates a steady increase in breastfeeding among infants however slight declines in 2022 among the 6 and 12 month old infants.

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, 40 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 2022, 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 continue to be supported by Title V funds. Additionally, access to donor breastmilk is made possible through Title V funds and made available as indicated to infants in the NICU.

In September 2022, the MCH and WIC programs coordinated the CNMI Breastfeeding Bootcamp resulting in 21 health system staff members completing certification as Certified Breastfeeding Authorities (CBAs). Participants completed 35 hours of instructor-led sessions and completed a post course assessment to obtain a three-year certification as a CBA. Participants included staff members from the hospital nursery, NICU, obstetrics, Children's Clinic, Women's Clinic, Home Visiting Program, WIC program, Immunization, and the Tinian Health Center.

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 including vaccinations as they became available to children and eventually to infants in June 2022. Clinic staff, including medical and nursing leadership, focused on responding to COVID-19 cases and implementing COVID-19 vaccination across health system clinical sites as well as outreach locations.

Activities related to this strategy were carried into FY 2023. 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 continued into FY2023.

Evidence Based Strategy Measure 4.1: Percentage of WIC infants breastfed through 6 months.

Year	2021	2022
Percentage	44.6	39.9
Numerator	187	164
Denominator	419	411

The CNMI has identified the percentage of WIC infants being breastfed through 6 months of age as an evidence based/informed strategy measure for the perinatal/infant health domain. The strategies being implemented and the work around breastfeeding in the CNMI is conducted in partnership with the CNMI WIC program. The WIC program in the CNMI has a tremendous reach within the perinatal/infant health domain and thus the MCH Title V efforts to increase breastfeeding rates in the CNMI are done in collaboration with WIC. The objective for this ESM is to increase the percentage of WIC infants being breastfed through 6 months of age to 58 percent by 2025.

Priority: Prevention of adverse infant outcomes through Prenatal Care

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

Prenatal Care	2016	2017	2018	2019	2020	2021	2022
Percent of Pregnant Women	43.4	45.8	47.5	47.9	55	67	62
Numerator	319	297	323	334	347	382	290
Denominator	735	648	680	697	631	572	470

Data Source: CNMI HVSO

In 2022, 62 percent of non-tourist live births were to women who initiated prenatal care within the first trimester of

pregnancy. Additionally, the CNMI preterm birth rate in 2022 was 12.3 percent and 10.8 percent of live births were identified as low birthweight.

Strategy: Provide service navigation for pregnant women

In FY 2022, a partnership between MCH Title V, CNMI Breast and Cervical Cancer Screening Program (BCSP), and the Women's Clinic enabled monthly outreach clinics for a Women's Health provider to the island of Rota, expanding access to preventive women's visits including prenatal care for the population on the island of Rota.
Additionally, in FY2022, MICAH programs collaborated with the CHCC Outpatient Clinics to develop policies, standard operating procedures, and clinic outreach scheduling to support the implementation of a robust mobile clinic strategy in FY2023, where comprehensive women's health services and well-child clinics will be offered. The CHCC Mobile Clinic will serve as an additional clinic site where primary and preventive health services will be brought to village settings across the island of Saipan and include after-hours availability to be able to accommodate working community members and families.

The efforts around increasing access to prenatal care services will support the MICAH programs efforts for providing service navigation for pregnant women to be able to access early and adequate prenatal care. The MCH Services Manager works closely with the CNMI Family Planning Program and Women's Clinic providers to ensure women are able to access no cost pregnancy testing services and in addressing barriers to initiating prenatal care, such as lack of insurance or transportation challenges. In FY2023, the Mobile Clinic will become an additional clinic location for pregnant women to be able to access prenatal care.

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

Perinatal/Infant Health - Application Year

The CNMI remains committed to the current work of promoting breastfeeding and prenatal care as a means of impacting infant health and throughout the life course. By strengthening existing partnerships with WIC program, MICAH Programs can continue to strengthen the guiding principle of collaboration and creating community change. Priorities identified for the CNMI Infant population are the prevention of adverse birth outcomes through Prenatal Care and Breastfeeding. These priorities continue from the previous 5-year cycle. The details below outline activities planned for FY 2024 (October 01, 2023 through September 30, 2024).

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

Priority Need 2: Breastfeeding

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

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

Strategy: Implement workplace breastfeeding policies/support

In FY 2022, due to the COVID-19 pandemic, the MCH program was not able to conduct activities around workplace breastfeeding policies and support. Implementation work related to this strategy continued into FY 2023.
There are many factors that contribute to the CNMI's breastfeeding rates. Support for breastfeeding mothers in the workplace through workplace policies on breastfeeding is critical for women to sustain breastfeeding their infants at least until 6 months of age. There is evidence to suggest that working full-time outside of the home is related to a shorter breastfeeding duration. As mothers are one of the fastest growing segments of the labor workforce, we need to ensure that interventions are in place to support them and their infants.

In FY2024 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 2024, October 2023 through September 2024, the following activities provide an outline of the strategy that will be implemented for improving the percentage of babies breastfed through 6 months in the CNMI:

Workplace Breastfeeding Support

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

- Publish Community awareness products and other messaging to promote the workplace breastfeeding initiative.

ESM 4.1: Percentage of infants breastfed through 6 months.

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

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

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

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

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

Strategy: Provide service navigation for pregnant women.

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

There is moderate evidence that supports patient navigation as an effective intervention aligned with the percentage of women accessing preventive healthcare.

For FY 2024, October 2023 through September 2024, the following activities provide an outline of the strategy of providing service navigation for pregnant women in the CNMI:

Service Navigation for Prenatal Women

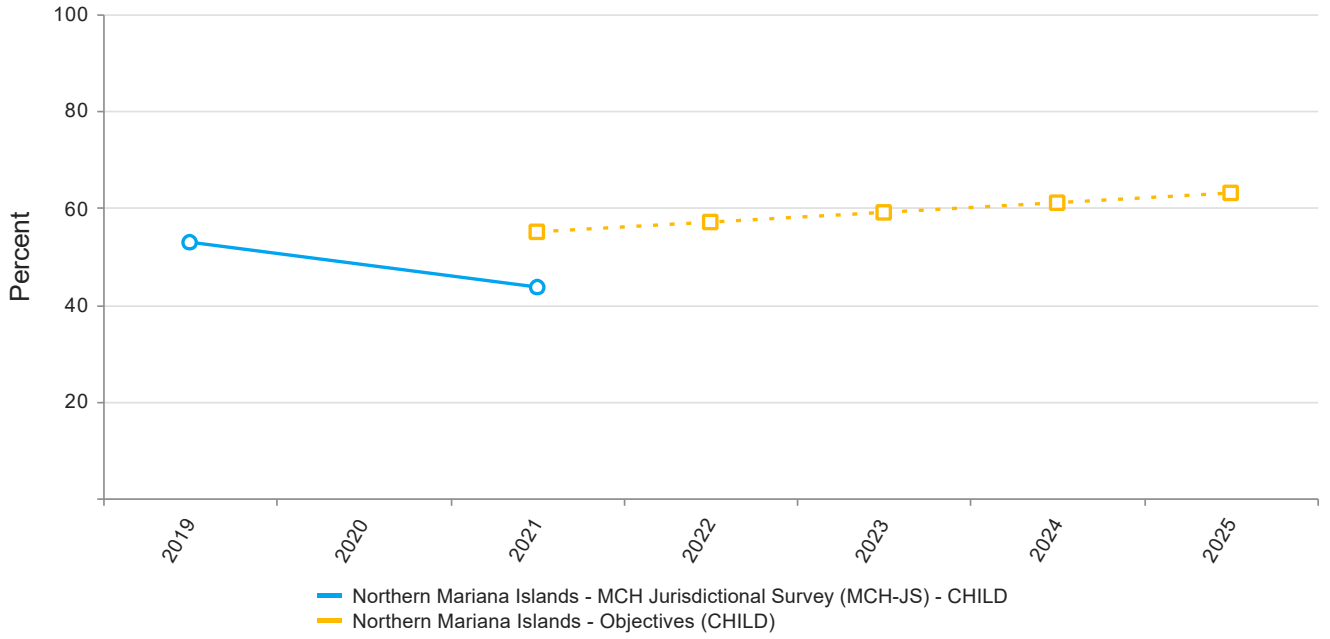
- Increase partnerships to strengthen identification and referral of pregnant women for service navigation
- Partner with Family Planning to promote free pregnancy testing to identify pregnant women early and connect with service navigation when needed
- Integrate screening for social determinants of 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**	**2022**
Annual Objective			57	57
Annual Indicator	52.7	52.7	43.5	43.5
Numerator	2,769	2,769	2,393	2,393
Denominator	5,253	5,253	5,498	5,498
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019	2021	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			10	15
Annual Indicator			0	0
Numerator			0	0
Denominator			3	8
Data Source			MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	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/food security and safe school and neighborhood programs to promote 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 FY2022, planned activities to address MCH Child Health priorities were impacted by the COVID-19 pandemic. The priority focus for the pediatric population was to ensure all children received COVID-19 vaccination to protect against severe disease, hospitalization, and even death among the pediatric population as the CNMI experienced its first significant surge of COVID-19 infections at the start of FY2022. Efforts were also made to address vaccination hesitancy in partnership with the CNMI Public School System and pediatric medical providers.

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

Strategies identified to help promote physical activity, as well as overall health among children, is increasing the number of children completing well-child visits. Well- child visits are an opportunity for children to receive important preventive screening services as well as a chance for parents and families to get anticipatory guidance and information on recommendations that include nutrition, physical activity and other factors that may contribute to obesity. Additionally, referrals to available community resources to help parents and families support their children, including in the area of obesity prevention and treatment, will be made accessible to them during well-child visits.

In FY2022, the MCH program led efforts for establishing a partnership with the Northern Marianas College Expanded Food Nutrition Education Program (EFNEP) and implementing a referral process for families seen at the CHCC Children's Clinic to access an evidence based nutrition and physical activity program provided at no cost. In addition, after review and assessments were conducted, the strategy to address priority need 4 on child health and obesity related issues was revised for FY2023 to increasing the number of children and their families who enroll into an evidence based nutrition education and physical activity curriculum. While the CNMI MICAH programs will continue its efforts for supporting increases in children accessing well-child visits, special attention and efforts will be placed on connecting families to nutrition education and physical activities opportunities.

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

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

Year	2020	2021	2022
Percent	52.7*	43.5*	43.5*
Numerator	2769	2393	2393
Denominator	5253	5498	5498

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

The data source for the NPM 8 is the MCH Jurisdictional Survey. For the 2020 reporting year, based on the survey conducted in 2019, it was estimated that 52.7 percent of children ages 6 through 11 years were physically active at

least 60 minutes per day. The 2021 and 2022 reporting year utilizes data from the survey conducted in 2021 which estimates that the percentage of children ages 6 through 11 years who were physically active at least 60 minutes per day was 43.5.

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. In addition to promoting preventive visits through partnering with the Immunization program during vaccination campaigns, the MCH Title V worked closely with the CHCC outpatient clinics department to finalize plans, policies, and scheduling strategies to begin providing preventive visits, including for pediatric patients, through the newly acquired Mobile Clinic. Serving as an additional clinic location, the mobile clinic provides primary and preventive care visits at various village locations, offering weekend hours, as part of efforts to increase access to well-visits for the CNMI population. In FY2022, the CNMI MCH Title V team and MICAH programs staff members worked closely with the mobile clinic staff to develop policies and procedures for administering comprehensive services to be made available through the mobile clinic beginning FY2023. Additionally, in FY2022, MICAH programs staff members provided training to Community Health Workers (CHWs) that are assigned to the Mobile Clinic on topics such as: routine and COVID-19 vaccinations for children, developmental screenings, and referrals to services such as WIC and other programs focused on improving health for the MCH populations.

In April 2022, Immunization clinics were expanded to offer Saturday walk-in clinics for community members, most especially children, to get caught up with routine vaccinations. The additional hours provide working families with a chance to access preventive services outside of the normal business hours and the weekend hours offer access without the need for children to miss school or classes.

Evidence Based Strategy Measure 8.1

ESM 8.1 was revised from the Percentage of 6- 11-year-old children accessing well-child and preventive care visits to the Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum. This revision better aligns with the updated strategy identified for targeted activities that focus on physical activity and obesity related issues identified during the 2020 CNMI MCH comprehensive needs assessment process. In the latter part of FY2022, the MCH program and CHCC Children's Clinic established partnership for referrals of children and their families to an evidence based program. There were a total of 8 referrals made in FY2022. Quality improvement activities are currently on-going to test strategies for improving referrals, enrollment and completed of the program.

Strategy: Increase community awareness on physical activity for children.

The CNMI CHCC focused a majority of its community awareness efforts on containing the COVID-19 surges that occurred in FY2022 with strategies aimed at increasing vaccination coverage, community based testing, treatment, and other infection control recommendations as mechanisms for preventing severe disease and hospitalizations. The community awareness activities focused on physical activity for children that were planned for FY2022 were postponed till FY2023.

Child Health - Application Year

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

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

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

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

Promoting healthy weight during childhood is crucial in leading into optimal health in adulthood. The CNMI has identified the priority need of obesity related issues including nutrition and physical activity, as it has been identified high risk 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% by 2025.

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

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

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

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

In FY2023, CNMI MCH Title V program worked with the CHCC Children's Clinic to establish a partnership with the Northern Marianas College's Expanded Food Nutrition and Education Program (EFNEP). The partnership enables referrals from the Children's Clinic to the EFNEP's evidence based nutrition education program for children and their families.

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.

The CNMI MCH Title V Program and MICAH programs staff will continue to work and expand upon the partnership with the NMC EFNEP in FY2024, with the goal of increasing access the number of families accessing and completing the evidence based food and nutrition program. From October 2023 through September 2024, 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:

- Conduct monthly assessment on the number of referrals, enrollment, retention, and completion of the EFNEP program among families referred by the CHCC Children's Clinic.
- Complete quarterly meeting with NMC partners to review monthly assessment results and implement quality improvement activities for areas that may need improvement.
- Finalize an MOU to outlining the partnership responsibilities along with a finalized referral and reporting protocol.

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 2024, October 2023 through September 2024, 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

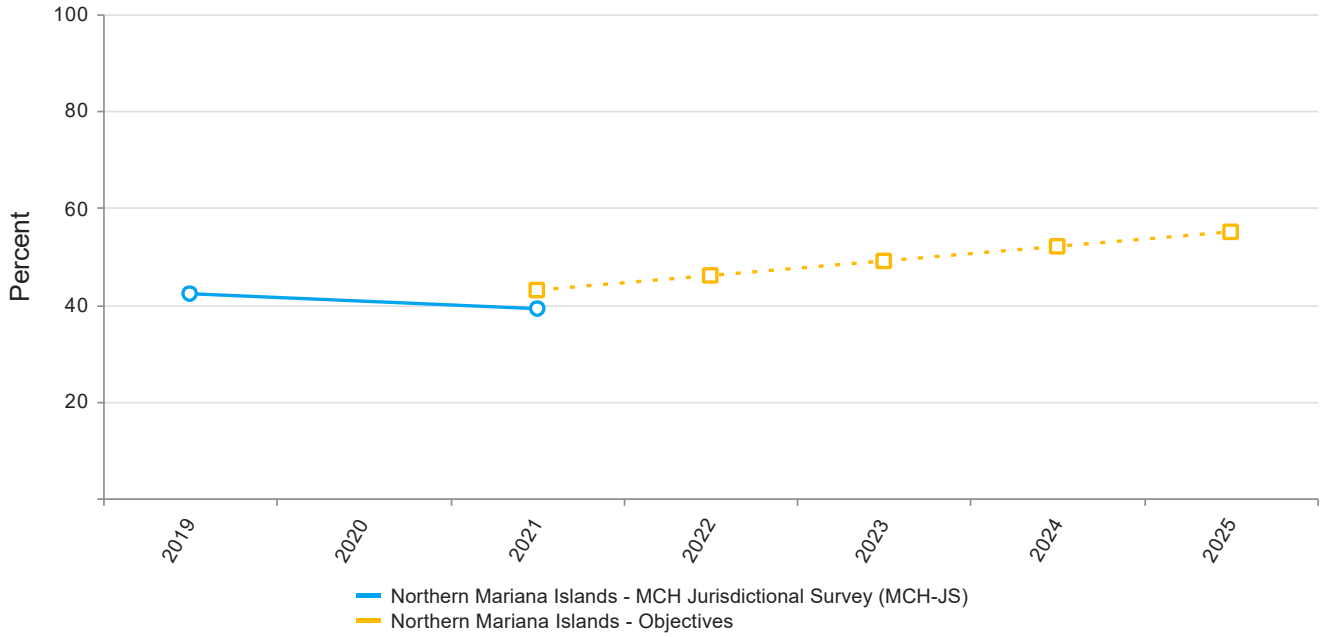
- Revise and finalize social media advertisements, TV commercial content, radio scripts, and newspaper content layout.
- Monitor and evaluate reach and effectiveness of the advertisements and promotions activities.

[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**	**2022**
Annual Objective			46	46
Annual Indicator	42.4	42.4	39.3	39.3
Numerator	2,593	2,593	2,156	2,156
Denominator	6,119	6,119	5,493	5,493
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

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

Annual Objectives			
	2023	2024	2025
Annual Objective	49.0	52.0	55.0

Evidence-Based or –Informed Strategy Measures

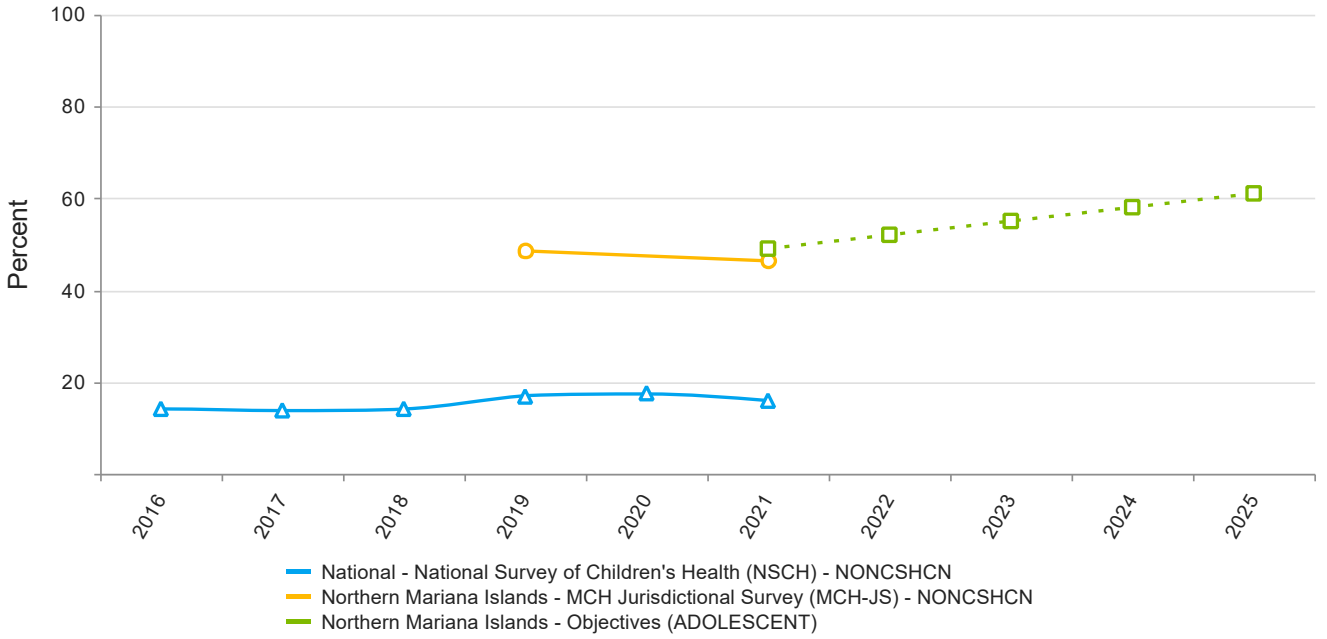
ESM 10.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	12.5	13.0	13.5

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**	**2022**
Annual Objective			52	52
Annual Indicator	48.4	48.4	46.3	46.3
Numerator	2,788	2,788	2,306	2,306
Denominator	5,761	5,761	4,982	4,982
Data Source	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN
Data Source Year	2019	2019	2021	2021

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

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percentage of high school students served by SPED who received information on transition

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	15
Annual Indicator			0	5.8
Numerator			0	16
Denominator			271	277
Data Source			Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	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 ages 12 through 17 years who access preventive care visit at all CHCC sites	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 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 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

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

Priority Need

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

NPM

NPM 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 - Percentage of high school students served by SPED who received information on transition	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

Adolescent Health - Annual Report

Activities identified in the FY2022 (October 01, 2021 – September 30, 2022) MCH Title V work plan for the adolescent health domain were continuously impacted by the COVID-19 pandemic. The CNMI experienced its largest surge of community transmitted infections at the start of FY2022, in October. By the end of September 2022, the CNMI had reported 13,171 individuals who tested positive for COVID-19 since the start of the pandemic. Additionally, the CNMI reported 40 deaths were COVID-19 related.

Due to the pandemic, schools had shut down at the start of School Year 2021 – 2022 impacting many of the school based activities that the CNMI MCH Title V and other MICAH programs had planned. Public schools and many private schools continued remote learning, and later transitioned into a hybrid learning environment. Many of the outreach and presentations that were originally planned had been 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 2022 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 protection from severe disease when they transitioned back to face-to-face learning.

When COVID vaccinations became available for teens, the MICAH leadership worked closely with Public School System leadership to collaborate on strategies to quickly increase vaccination coverage rates among youth. Vaccination outreaches were conducted at schools and community centers in the various villages. Gift certificates to local clothing shops, fuel, or groceries were utilized as incentives to motivate teens and their families. Another strategy that was adopted early on during the implementation of COVID-19 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. This was critical for keeping coverage for vaccines like HPV and Tdap high among the adolescent population.

The priority need identified during the 2020 CNMI MCH comprehensive needs assessment process for the adolescent population was coping skills and suicide prevention. This priority need was aligned with national performance measure 10, percent of adolescents, ages 12 through 17 years, with a preventive medical visit in the past year. MCH intends to promote well visits for adolescents at which a holistic approach including promoting coping skills and preventing suicide as part of a behavioral health screening and assessment to be conducted at the well-visit. In addition, priority need 7, Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful was determined to be an area of focus for adolescents with and without special healthcare needs that needed to be addressed. Priority need 7 is aligned with national performance measure 12, Percent of adolescents with and without special healthcare needs, ages 12 through 17 years, who received services necessary to make transitions into adult health care.

In preparation for the upcoming School Year 2022 – 2023, the MICAH leadership-initiated planning meetings and implementation assessments to conduct outreach in the schools. During this reporting period, the Public Health Services programs including the MICAH Programs and Non-Communicable Disease (NCD) Programs, had developed the teen health outreach presentations and participated in trainings to conduct basic health screenings in the schools. Basic health screenings include glucose checks, blood pressure monitoring, Body Mass Index (BMI) measurements, interpretation of screening levels, and referrals and assistance in accessing adolescent well visits. The outreach initiative was eventually piloted with a high school on the island of Saipan in FY2023 and will be expanded to all CNMI high schools during the 2023-2024 school year (FY2024).

Additionally, in 2022, the CNMI MCH Title V staff partnered with the territorial mental health agency, the Community Guidance Center (CGC), to develop and implement the CNMI Pediatric Mental Health Care Access (PMHCA) project as a mechanism for building capacity within the CNMI pediatric and adolescent primary care providers to be able to effective screen, treat, or refer patients for mental and behavioral health issues. The MCH Title V program staff are actively engaged with the project activities including participation in the CNMI PMHCA project advisory committee. Through funding awarded to the CHCC CGC, by the HRSA MCHB, access to psychiatric consultation, coordination and support, and provider training will be made available to CNMI pediatric and adolescent primary and preventive care providers. This work will improve adolescent preventive medical visits strengthening and/or integrating screening for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues.

Priority Need 5: Coping Skills and Suicide Prevention

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

Adolescent Well-visits	2020	2021	2022
Percent	42.4	39.2	39.2
Numerator	503	2,156	660
Denominator	6,215	5,493	6,177

Data Source: CNMI MCH Jurisdictional Survey

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 preventative health care in compared to the 2020 reporting year.

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 closures and periodic transition between face-to-face and virtual learning as schools responded to COVID-19 surges. MICAH programs staff worked creatively to engage individual school campuses and was able to conduct classroom presentations with high school students through both virtual methods and physical attendance. 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.

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

Year	2021	2022
Percentage	22	12.1
Numerator	1378	749
Denominator	6256	6177

In 2021, there were 1,378 teens ages 12 through 17 years who accessed preventive services via CHCC sites. There was a decrease in the number and percentage of teens accessing preventive health services in 2022 with 749 (12.1 percent) teens from the age group accessing services.

However, it should be noted that the CNMI has some slight increases in the number of teens within the age group accessing Family Planning services and increases in male teens being served. In 2020, there were was 107 teens served, and 109 and 110 in 2021 and 2022, respectively. These numbers are significant increases compared to 2019, prior to the COVI-19 pandemic, where just 82 teens were served. There was a 34 percent increase in the number of teens 17 years and younger seen in 2022 compared to 2019. The MICAH programs have been working diligently to ensure access to confidential adolescent health services throughout the pandemic remained uninterrupted.

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

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

Transition (Non-CSHCN)	2020	2021	2022
Percent	48.4	46.3	46.3
Numerator	2,788	2,306	2,306
Denominator	5,761	4,982	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. Compared to the previous year of data collection, there was a slight decrease in the number of teens whose families reported that they received transitional services.

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

Similar to strategy 1 in the adolescent health domain, strategies to increase the percentage of teens ages 12 through 17 years that receive transition services focused on leveraging the existing partnerships the CHCC and MICAH programs had with the Public School System. The partnership activities were impacted by the COVID-19 pandemic in the reporting period. The activities related to this strategy were carried into FY2023 plans.

Other Adolescent Health Activities

In June of 2022, MICAH Programs partnered with the Pride Marianas Youth (PMY) to coordinate the Pride at the Park event for CNMI youth and their families. The event was attended by almost 200 community members and families and was conducted through the efforts of a variety of community agency partners, including: CNMI Public School System, Division of Youth Services, Northern Marianas College, T-Project, CNMI Youth Affairs Office, Community Guidance Center. Entertainment, food, games, and most importantly, access to youth friendly services and information were made available during the annual event.

Also in 2022, the MICAH programs began working closely with the CHCC Children's Clinic department on tracking

the number of teens that complete preventive well-visits. As part of monthly quality improvement efforts, the unit monitors the number of teens that visit to support data driven decision making and to inform interventions for improving teen well-visit rates.

In an effort towards improving staffing capacity to support the MCH Title V workplan activities for the adolescent health domain, the MICAH unit began recruitment for an Adolescent and Reproductive Health Manager in 2022. This team member is now responsible for overseeing the implementation of workplan activities and monitoring of progress in meeting goals and objectives relating to the adolescent health domain.

Adolescent Health - Application Year

Adolescent health continues to be a significant component in Public Health with collaboration amongst several partnerships. The MICAH Programs maintains an important partnership in addressing adolescent health with 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. Therefore, utilizing a school-based approach to providing preventive programs outreach and information is an ideal strategy. As a public health focus, preventing risky behaviors in childhood and adolescence is less challenging when compared to trying to change unhealthy behaviors in adulthood. MCH will continue its efforts towards improving adolescent health by focusing on the priorities of improving transition services, and promoting coping skills and suicide prevention among teens.

Life skills development, such as budgeting, cooking, workforce training and healthy recreation are also important focus areas under this priority. Promoting positive coping mechanisms can be accomplished with yearly mental health screenings that can lead to suicide prevention efforts and addressing bullying/ bullies. Preventative health well visits for adolescents, which are fully covered under public health insurance (i.e. Medicaid), can promote overall physical health (immunizations, healthy eating, and oral health), as well as social emotional health (self-awareness, coping skills, managing stress). Social emotional health can also be enhanced by trained adults and mentors to help adolescents navigate life skills and set goals (high school completion, employment, youth development). Given that adolescents have a natural desire to become active agents in society and community, this priority can be promoted through community partnerships and engagement, and can reinforce protective factors and promote prevention of risky behaviors.

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 increase the number of adolescents accessing preventive visits.

In FY2023, the MICAH and Non-Communicable Disease programs worked collaboratively with the CNMI Public School System to pilot an on-campus health screening event focused on engaging with teens in the local high schools on the topics of diabetes prevention and preventive care visits. In partnership with school nurses, Public Health Staff conducted presentations and provided diabetes and hypertension screening. Students were provided screening result information as well as guidance to bring home to their parents regarding adolescent well visits and information on support for accessing them. Students that were identified with potential health risks, based on their

BMI, blood glucose, or blood pressure screening were provided follow-up care through the CHCC Children's Clinic. Working with pediatric providers, the MCH Services Manager provided service coordination to ensure that students identified needing follow-up were seen by a pediatrician. As a result of this project, approximately 40% of the targeted high school population were screened and provided information and education regarding healthy lifestyle behaviors to prevent diabetes as well as referrals to preventive visits. Utilizing the results from the pilot outreach project, the MICAH programs will work to expand the activity to all public high schools in the CNMI in FY2023.

For FY 2024, October 2023 through September 2024, the following activities provide an outline of the strategy in partnering with the school system to identify and refer adolescents to well-visits:
School Partnership to Identify and Refer for adolescent well-visits:

- Partner with the CNMI Public School System to develop and outreach schedule to provide school based presentations, screenings, and referrals for accessing adolescent well visits.
- Procure needed screening and outreach supplies.
- Utilizing survey data gathered from the pilot phase to improve and update outreach presentation materials.
- Complete all scheduled outreach events.
- Evaluate the outreach and referral process
- Complete a report and present outreach outcomes and evaluation results to key stakeholders.

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

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

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.

Activities that were identified to carry out the strategy for national performance measure (NPM) 12- Transition were

postponed in FY2022 due to challenges due to the COVID-19 pandemic. The activities were continued into FY2024.

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

For FY 2024 October 2023 through September 2024, the following activities provide an outline of the strategy in for providing transition services and information to adolescents in the CNMI:

Transition Services Presentations

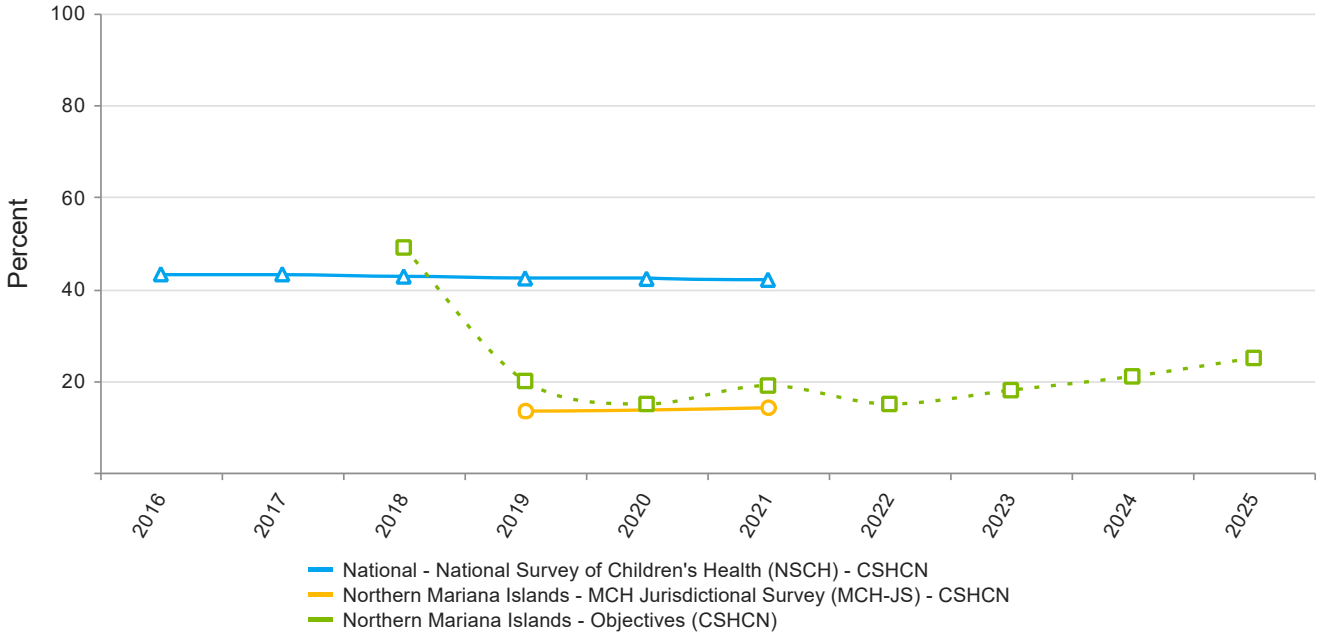
- Develop presentations utilizing information available via Got Transitions and PATCH program toolkit.
- Partner with the school system and Parent Teacher Association to develop a presentations schedule.
- Implement transition assessments for youth and parents of youth during presentation sessions.
- 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**	**2022**
Annual Objective	20	15	15	15
Annual Indicator	13.3	13.3	14.1	14.1
Numerator	141	141	176	176
Denominator	1,059	1,059	1,252	1,252
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	49	20	15	19	15
Annual Indicator	19.6	19.6			
Numerator	54	54			
Denominator	276	276			
Data Source	CSHCN Survey	CSHCN Survey			
Data Source Year	2018	2019			
Provisional or Final ?	Provisional	Provisional	Provisional		

Annual Objectives			
	2023	2024	2025
Annual Objective	18.0	21.0	25.0

Evidence-Based or –Informed Strategy Measures

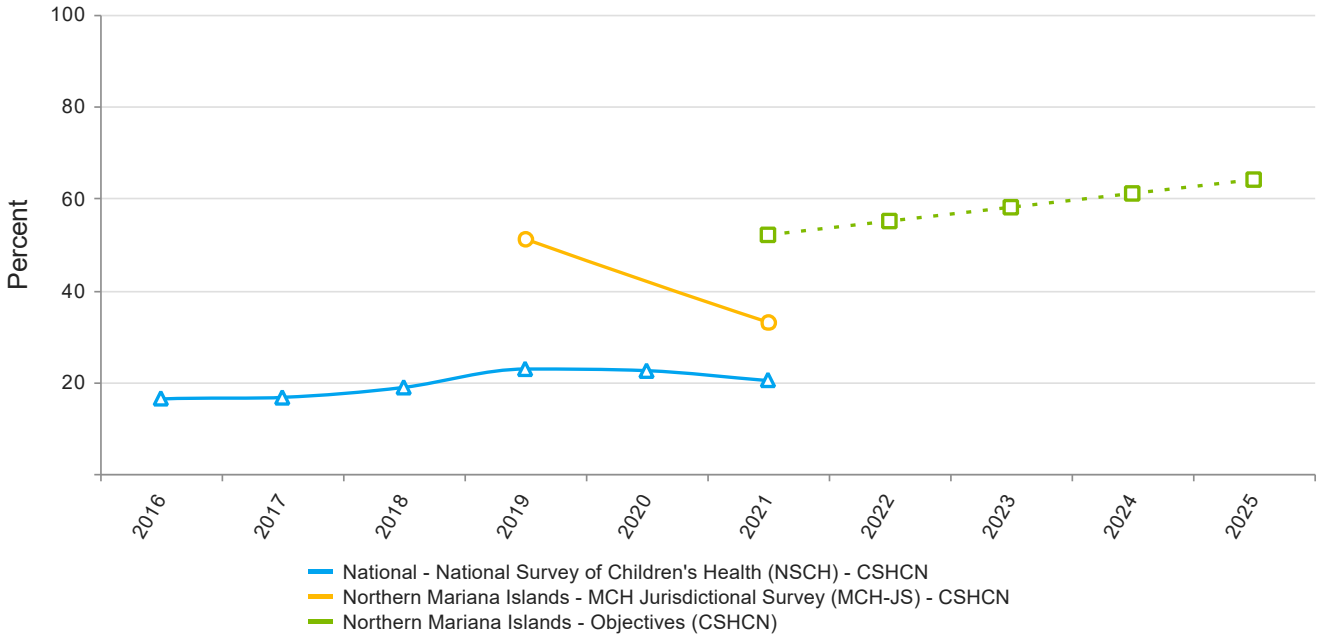
ESM 11.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	20
Annual Indicator			81	0
Numerator			51	0
Denominator			63	63
Data Source			F2F Medical Home Survey	F2F Medical Home Survey
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			55	55
Annual Indicator	51.0	51.0	32.8	32.8
Numerator	183	183	167	167
Denominator	358	358	511	511
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021

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

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percentage of high school students served by SPED who received information on transition

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			10	15
Annual Indicator			0	5.8
Numerator			0	16
Denominator			271	277
Data Source			Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	
Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful.	
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 13%.	
Strategies	
Conduct outreach and provide peer support to families of children and youth with special healthcare needs.	
Strengthen partnerships with the CNMI Disability Network Partners (DNP) to establish referral mechanisms to connect CSHCN to medical homes	
ESMs	**Status**
ESM 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

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

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 - Percentage of high school students served by SPED who received information on transition	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 2022 (October 01, 2021 through September 30, 2022). The CNMI MCH priorities for Children with Special Healthcare Needs (CSHCN) focus on providing support to parents and caregivers in navigating systems and supporting CSHCN and their families with transition into adult care, priority needs 6 and 7 identified through the 2020 CNMI MCH comprehensive needs assessment. Priorities 6 and 7 align with NPM 11- Percent of children with and without special health care needs, ages 0 through 17, who have a medical home and NPM 12- Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.

Data to inform NPM 11 and NPM 12 is gathered from the CNMI MCH Jurisdictional Survey, which was conducted in 2019 and again in 2021. The 2021 survey results indicated that only 14.1 percent and 32.8 percent of CSHCN, ages 0 through 17 reported having a medical home or received services to transition into adult health care, respectively.

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 the fall of 2021.

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.

To address the priorities the CNMI MCH Programs underwent a restructuring. The CNMI MCH is now the Maternal, Infant, Child and Adolescent Health (MICAH) Programs within the Division of Public Health Services. MICAH Programs consists of several programs and services that serve women, infants, children, children with special healthcare needs and adolescents. In May 2022, the Program Manager for the Family/Professional Partnership-CSHCN Program had resigned. Ms. Shiella Marie Deray, the EHDI Program Coordinator at that time, was promoted to the CSHCN Program Manager under the MICAH Programs. Under the CSHCN unit are the

- Child-Find Activities – ASQ 3 Developmental Screening
- CNMI Early Hearing Detection & Intervention Program
- CNMI Family-to-Family Health Information Center
- Shriners Outreach Clinic – Honolulu
- Newborn Bloodpsot Screening

The re-structuring of MICAH-CSHCN unit was to ensure that referral services were streamlined and services are coordinated through a variety of programs available through the health department and partner agencies. The restructuring also worked to reduce redundant referrals or service duplication to increase efficiency and quality in the services being provided to families.

The Family to Family (F2F) Health Information Center, under the MICAH Programs leads MCH activities focused on

outreach, peer support and family engagement, with a focus on 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 are referred 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 2022 & Down Syndrome Awareness Month in October of 2022. The CNMI F2F HIC focuses on building partnerships with parents to support parent leaders on Saipan, Tinian, and Rota.

In February 2022, the program was able to recruit Ms. Chrislaine Manibusan as the programs' Family Support Specialist (FSS). Prior to working as a Family Support Specialist, Ms. Manibusan worked at the CNMI PSS Headstart Program and also is a parent of children with special healthcare needs. Utilizing her lived and personal experiences, Chrislaine has been able to excel in connecting with other parents and families and in organizing peer support activities and community events.

In FY2022, MICAH programs were able to coordinate First Aid/CPR certification classes for families of CSHCN. Through this event, 20 parents were able to successfully receive a 2-year adult/pediatric first aid/CPR certification.

Additionally, the Family Support Specialist was selected as an AUCD-Learn the Sign Act Early Ambassador for the CNMI. This is a 2-year cohort. The purpose of the Act Early Ambassadors is to expand the reach of the "Learn the Signs. Act Early." program and support their respective state's work toward improving early identification of developmental delays and disabilities, including autism. The activities that are outlined under as part of the Act Early Ambassador program includes:

- Conducting outreach to provide resources regarding development milestones to programs that serve children ages 0-5.
- Conducting outreach to primary care providers by demonstrating the use of the Learn the Signs Act Early App.

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

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

Year	2021	2022
Percentage	81	0
Numerator	51	0
Denominator	63	0

The CNMI MCH Title V utilizes an annual survey of parents enrolled in the Family to Family Health Information Center to inform ESM 11.1. In 2021, 81 percent of the survey respondents reported that they had a medical home for their CSHCN. In 2022, due to impacts of the pandemic, the MCH Title V was not able to conduct the survey in time to provide an update as part of this report. The update will be provided in the next reporting year.

From October 2021 thru September 2022, the CNMIF2F HIC conducted nine (9) virtual learning sessions attended

by families and professionals, figure 1. The F2F leverages partnerships throughout the health department and external agencies to coordinate virtual learning opportunities.

Figure 1: F2F Learning Sessions offered in 10/2021-09/2022

Month	Topic	Trainer/Facilitator	Participants
November 2021	Lead Poisoning	Dr. Julio Pena, CHCC Pediatrician	24
December 2021	Promoting Healthy Pregnancy Outcomes	Gayline Blau, CHCC Nurse Practitioner/Tony Yarobwemal, MCH Program Manager	8
January 2022	Jumpstart to Your Future	Sam Santos, Office of Vocational Rehabilitation Transition Specialist	28
February 2022	SSI vs SSDI	Elsie Tilipao, NMPASI Program Manager	35
May 2022	Supporting Your Child's Mental Health	Kayla Atalig, Mental Health & Disabilities Coordinator	16
July 2022	Healthy Moving	Zumba Team	18
August 2022	Promoting Healthy Lifestyle in Families & Children	Erika Vagas, CHCC Registered Dietician	27
August 2022	Parental Rights	Elsie Tilipao, NMPASI Program Manager	48
September 2022	Healthcare Transition from Pediatric to Adult Health Care	Dr. Michael Do, CHCC Chief of Pediatrics	16

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.

The CNMI MCH Title V program continues to focus on building and sustaining effective partnerships with the CHCC Children's Clinic providers and nurses. Part of this partnership resulted in the integration of and a dedicated office

for MCH Services Coordination for the Women's and Children's Clinics. The MCH Services Manager is stationed at the clinic setting where service coordination and referrals are arranged for pregnant women and children with special healthcare needs. In addition to improvement in the coordination of MICAH services and referrals, the collaboration has helped to further strengthen communication and partnership between the clinical staff and MICAH programs.

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. An MCH Title V supported Community Health Outreach Worker (CHOW) provides support at the children's clinic for families in completing recommended developmental screenings and coordinates access to the Northern Marianas College (NMC) Expanded Food Nutrition Education Program (EFNEP) for at risk children who are referred by pediatric providers.
Additionally, MCH Title V funds are used to support the salaries of 3 Community Health Outreach Workers (CHOWs) who receive referrals and provide families of CSHCN with support to navigate the healthcare system and other programs available to CSHCN.

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 FY2022 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 which made it difficult to finalize scheduling for presentations and educations sessions to occur. Schools were also prioritizing efforts to minimize COVID-19 school transmissions and vaccination among its student population. As an alternative, MICAH Programs reached out to pediatric providers to conduct a learning session focused on healthcare transition from pediatric care to adult care. There are plans to collaborate with Northern Marianas College, University Center for Excellence in Developmental Disabilities (NMC UCEDD) to conduct a symposium focused on transition. The transition topics will cover programs and services from infancy to adolescents and eventually transitioning into adulthood. Topics range from education and healthcare transitions, including all programs that serve infants, children, adolescents and CYSHCN.

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

Year	2021	2022
Percentage	0	5.8
Numerator	0	16
Denominator	271	277

The CNMI MCH Title V utilizes ESM 12.1, percentage of high school students served by SPED who receive information on transition as an indicator for assessing progress on strategies implemented to improve access to transition services. In 2022, due to impacts of the pandemic, activities that were planned as part of the strategy identified to address priority need 7 did not materialize. The program did however coordinate a virtual presentation on transition in partnership with the Chairperson for the CHCC Pediatrics Department, Dr. Michael Do, in which 16

families of children served by SPED received information on transition.

Other CSHCN Activities

MCH Title V funds are used to support developmental screening activities in the CNMI as part of efforts to identify CSHCN. To further support this activity, CNMI F2F HIC hosted a training on conducting ASQ 3 Developmental Screening. There was a total of 9 staff from various programs and clinics of CHCC that attended the training.

Figure 2: Number of children screened with ASQ and identified as needing monitoring or below developmental cut-off, 2020 – 2022.

Year	Total Number Screened	Number Identified for monitoring or at below cut-off
2020	1,256	389
2021	1,031	372
2022	1,094	216

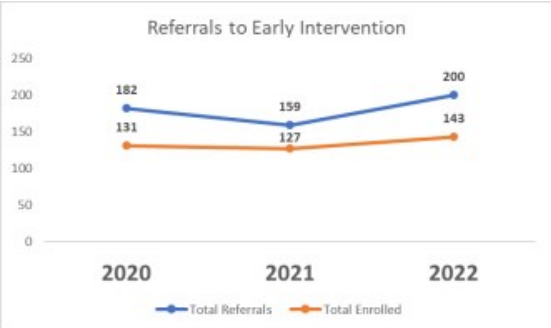
Source: MICAH Program

In 2022, a total of 1,094 developmental screenings were conducted at the Children's Clinic during well-child visits. Children who are identified with developmental risk and who need further assessment are referred to the Early Intervention Program or to the Special Education Program. A total of 216 (19.7%) in 2022 were children identified as requiring additional monitoring or referral to Early Intervention services.

Early Intervention referral data reports an increase in both the number of referrals to EI and the number of families served compared to the previous year. During the mid-year of 2022, EI started providing face-to-face services full time, however, virtual EI services were an option for families who prefer a combination of some virtual and some in person visits.

A total of 143 families were served through the Early Intervention Program during the school year 2021-2022. Of those families, 60 children were eligible due to established condition and 83 were identified with developmental delay. In 2022, 80% of infants and toddlers referred to EI were from CHCC. Referrals to EI also came from private clinics, daycare, Early Headstart Program and parents.

Figure 3: Total Referrals to Early Intervention Services, 2020- 2022



Source: CNMI Early Intervention Program

The CHCC-Early Hearing Detection & Intervention (EHDI) Program continues to meet the JCIH national benchmarks. As in the previous year, 2022 data illustrates that 99% of babies born in the CNMI received a newborn hearing

screening before one (1) month of age. Of the babies that were screened only one (1) infant did not receive a timely newborn screening. Improvements in newborn hearing screening were made compared to previous years. Out of the 133 babies that needed to come back before 3 months of age, only three (3) babies were lost to follow-up (LTFU). The program is exploring additional strategies for tracking and monitoring these LTFU babies to bring them back for their hearing screenings such as working with WIC and Immunization Program.

Of the 3 babies that were referred to diagnostic audiological evaluation, 2 infants were diagnosed with hearing loss, 1 infant remains lost to follow up, figure 4. Both identified infants were referred to and enrolled with Early Intervention. To further build on capacity with the CNMI EHDI Program, the program collaborated with Dr. Angie Mister, PSS Audiologist to facilitate training on hearing screening using the Otoacoustic Emission Machine (OAE). Dr. Mister successfully trained three (3) CHOWs. All three (3) CHOWs are able to provide updated hearing screenings.

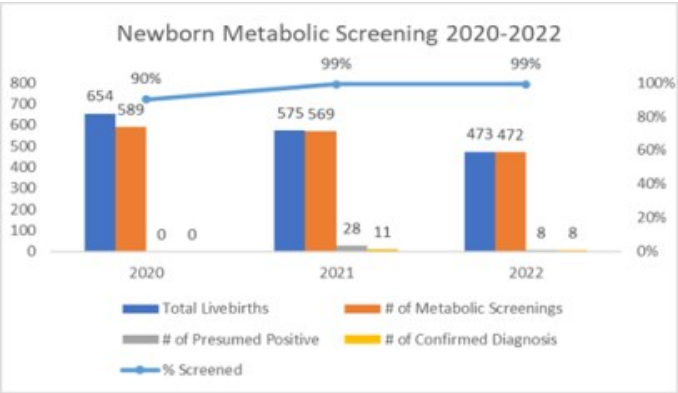
Figure 4: CNMI Newborn Hearing Screening, 2020- 2022

	2020	2021	2022
Births	654	575	473
Screened	648	569	472
Inpatient Pass	505	469	336
Inpatient Refer	138	100	133
Outpatient Pass	133	90	130
Outpatient LTFU	5	5	3
Outpatient Refer to DAE	5	5	3
DAE Pass	3	4	0
DAE Hearing Loss	1	1	2
EI Referral	1	1	2

Source: CNMI EHDI-IS

The MICAH unit works closely with the pediatrics and CHCC laboratory to ensure that newborn bloodspot services remain uninterrupted, identifying children who are identified as needing a secondary screening or diagnostic testing, and assist in contacting families to prevent lost to follow up, figure 5.

Figure 5. Newborn Bloodspot Screening, 2020-2022



Source: CHCC Carevue; CNMI EHDI-IS

Of the 473 live births in 2022, 99% completed a newborn bloodspot screening. This is a significant improvement compared to prior years. 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. All of the eight (8) infants that were presumed positive received confirmed diagnoses and are being followed-up by a primary care provider. MCH Title V funds are used to support shipping costs for the freight services for newborn bloodspot kits. Samples are required to be sent via expedited courier (FedEx) to Oregon Department of Health laboratory to ensure viability of samples.

The Shriner's Hospital Honolulu was able to continue their outreach services in the CNMI in October 2021 and May 2022, figure 6. Together with the follow-up visits, Shiners continued to provide orthotics at no charge to the families. In addition to the outreach clinics, Shriners continued to provide telehealth services. Additionally, in May 2022 the CHCC and Shriners Hospitals for Children signed a MOU to further sustain the partnership. There are discussions being made for expanding orthopedic services for the children in the CNMI, services such as minor treatment that would include surgery with the collaboration of CHCC's only orthopedic surgeon, Dr. Thomas Austin. Also, included in current planning, are to increase the number of outreach clinics to CNMI. Shriners regularly hold outreach services twice a year, and plans to increase for three (3) times a year are currently ongoing.

Figure 6. Shiners Outreach Clinic

Outreach Date:	Total Patients Served:	
October 2021	112	93 established patients / 19 new referrals
May 2022	103	73 established patients / 30 new referrals

Source: Shriners Outreach Clinic

Children with Special Health Care Needs - Application Year

The MICAH programs will continue to focus its efforts on improving early identification and screening programs for identifying and connecting children with special healthcare needs with early intervention services and other needed health services. Early intervention improves and enhances the development of a child with developmental delays, special needs, or other concerns. For MICAH, 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 substantial 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 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 FY2022 resulting from the COVID-19 pandemic that impacted the activities that were intended for the year and therefore some were carried into FY2023.

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. To help address this need, the MICAH CSHCN section has increased staffing size to strengthen capacity for improving early screening, diagnosis, and service coordination. The CSHCN section has increased the number of Community Health Outreach Workers serving CSHCN families from 2 to 4 and has a full time Family Support Specialist focused on family engagement and building capacity with parents and families of CSHCNs to be able to more effectively partner with medical providers and advocate for their needs. A restructuring of MICAH programs has also resulted in better alignment of programs and a more coordinated approach in service provision.

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 25% by 2025 by conducting outreach and providing peer support for families of children with special health needs.

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

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

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

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

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

Outreach and peer support will be provided by community health workers and the Family Support Specialist, who are part of the CSHCN program team. Monthly learning sessions and other capacity building activities will be made available for parents of CSHCN to attend to improve access to information and to improve partnerships between parents and medical providers and other CSHCN serving professionals including organizations that are a part of the Disability Network Partners (DNP).
There is evidence that community collaboration and outreach supports children receiving care within the medical home model resulting in increased contacts for things like well-child visits, specialty care, disease management and oral health[1].

For FY 2024, October 2023 through September 2024, 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 transition packets/materials for CSHCN families.
- 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.
- Conduct outreach in Rota and Tinian to enroll potential parent leaders for F2F HIC.
- 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 2024, October 2023 through September 2024, 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/face-to-face sessions on transition to families.
- Leverage partnerships with the teens from the Patch Program to include CYSHCN teens to be a part of the advisory group.
- Conduct surveys to acquire information regarding medical home and healthcare transition services.
- 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 and Patch Program.

[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 Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	15
Annual Indicator			2.1	34
Numerator			2	32
Denominator			94	94
Data Source			CHCC HUMAN RESOURCES	CHCC HUMAN RESOURCES
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	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 Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.

Objectives

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

Strategies

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

Cross-Cutting/Systems Builiding - Annual Report

A key finding in the 2020 CNMI MCHB 5 - year needs assessment suggested 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 MCH serving professionals, it is critical to provide capacity building and training opportunities to ensure a competent workforce, but also support retention, morale and productivity.

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

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

State Performance Measure 2- Percentage of CHCC staff and other professionals who serve MCH populations that receive training on MCH priorities and/or related strategies.

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

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

Strategy: Provide training to healthcare providers and other MCH serving professionals on MCH priorities and/or strategies that support improvements in national outcome and performance measures.

Activities under the cross-cutting/systems building domain were significantly 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, provide access to testing and treatment, and maintaining engagement with clients and community members as programs worked diligently in delivering services virtually.

Although limited due to the impact of COVID-19, the MICAH unit was able to offer the following MCH related trainings to Public Health staff and other MCH serving professionals:

Training Date	Training Topic	No. of participants	CNMI Priority
12/2021- 04/2022	One Key Question	6	Priority 1- Women's preventive screenings
09/26/2022- 09/30/2022	Breastfeeding Bootcamp	21	Priority 2- Breastfeeding

The updated SPM-2 modifies its focus to CHCC Public Health Service Staff including MCH serving professionals (Denominator); and CHCC Public Health Service Staff and MCH Service Professionals who successfully completed the training (Numerator). This measure improves the specificity and is a more realistic measure to reflect the strategy needed to address Priority 8.

CNMI MCH is investigating available options for providing online training to all Public Health Services unit staff and 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.

Discussions are ongoing with CHCC Health Information Technology and Professional Development coordinator for adopting an online platform or creating and implementing an online learning portal where staff members can access training materials and videos to support selected health topics that addresses the MCH populations.

Cross-Cutting/Systems Building - Application Year

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

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

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

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

Strategy: Provide training to CHCC Public Health staff and MCH serving Professionals.

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

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

Throughout FY2023, the MICAH programs staff are actively working to explore options to provide the training, including opportunities for on-site, virtual, or hybrid training delivery.

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 hundreds 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 2024 Application/2022 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 are received from clinical partners during these meetings. Meetings with partner programs, both internal to CHCC and external, are held frequently throughout the year where input and feedback is also received. The information provided through these meetings are a critical component in the identification and selection of priority areas and strategies to impact the measures selected.

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

In June of 2023, the MICAH Programs coordinated a stakeholder's meeting to gather feedback and input specific to strategies and activities for CNMI Women's Health. The meeting was attended by 50 participants representing various internal and external agency partners where MICAH team members provided updates on performance and outcomes measures, strategies, and plans for the upcoming fiscal year. Input gathered through the meeting included: expanding number of participants to allow for a larger number of stakeholders to attend; information on client satisfaction survey results need to be included in future meetings; engagement of more men in these discussions.

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 2022, the CNMI continued to utilize technical assistance available through the HRSA Maternal and Child Health Bureau (MCHB) and the Association of Maternal and Child Health Programs (AMCHP). Training and presentation events were attended virtually and included Title V Learning Labs, consultation with project officers and AMCHP regional representatives, the AMCHP national conference, and recurring region IX calls.

In 2023, the CHCC Division of Public Health Services established an Employee Relations and Engagement Committee focused on identifying employee recruitment, retention, and capacity building needs, in relation to the core competencies for public health professionals.

The CNMI MCH Program was scheduled to complete an assessment of staff capacity building and development needs to inform TA requests, however, the work was postponed due to the COVID-19 pandemic and redirection of health department efforts to contain the COVID-19 community outbreaks that occurred. This work is on-going and being conducted in partnership with the Employee Relations and Engagement Committee and the CHCC Human Resource office.

In 2022, the CNMI CHCC was awarded grant funds to support workforce development and technical assistance needs for the public health workforce. The funds will be used to support workforce development activities, to include training and technical assistance needs for the CNMI health department, including the MICAH unit. Technical assistance is being offered through the following national and regional partners:

- Association of State and Territorial Health Officials (ASTHO)
- Pacific Islands Health Officers Association (PIHOA)
- Public Health Accreditation Board (PHAB)
- National Network of Public Health Institutes (NNPHI)

Additionally, in the spring of 2023, the MICAH programs successfully secured funding through AMCHP to replicate the Providers and Teens Communicating for Health (PATCH) program in the CNMI. The MICAH staff are engaged in technical assistance through the AMCHP and the PATCH program developers on program implementation scheduled in 2023.

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 - Organizational Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Northern Mariana Islands

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 474,000	
A. Preventive and Primary Care for Children	$ 153,474	(32.3%)
B. Children with Special Health Care Needs	$ 146,544	(30.9%)
C. Title V Administrative Costs	$ 42,117	(8.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 342,135	
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)	$ 459,410	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 459,410	
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)	$ 933,410	
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)	$ 7,401,082	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 8,334,492	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > MCH Data Systems Linkage and Training Initiative	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant & Early Childhood Homevisiting Grant Program	$ 1,123,516
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Family Planning Program	$ 200,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 89,140
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PRAMS	$ 175,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Immunization and Vaccines for Children Grants	$ 1,266,906
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants, Children	$ 4,211,520

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 466,540 (FY 22 Federal Award: $ 473,287)		$ 473,287	
A. Preventive and Primary Care for Children	$ 149,186	(32%)	$ 156,803	(33.1%)
B. Children with Special Health Care Needs	$ 151,545	(32.5%)	$ 147,091	(31%)
C. Title V Administrative Costs	$ 41,049	(8.8%)	$ 42,117	(8.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 341,780		$ 346,011	
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)	$ 487,995		$ 465,967	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 487,995		$ 465,967	
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)	$ 954,535		$ 939,254	
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)	$ 10,877,895		$ 5,162,601	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 11,832,430		$ 6,101,855	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000	$ 55,459
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 172,236
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 867,026	$ 64,357
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 296,400	$ 170,463
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 96,750	$ 103,080
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 4,570,820	$ 849,924
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 4,601,879	$ 3,636,445
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020	$ 110,637

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 51,683	$ 43,892
2. Infants < 1 year	$ 51,682	$ 43,892
3. Children 1 through 21 Years	$ 153,474	$ 156,803
4. CSHCN	$ 146,544	$ 147,091
5. All Others	$ 28,500	$ 39,492
Federal Total of Individuals Served	$ 431,883	$ 431,170

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 90,434	$ 84,322
2. Infants < 1 year	$ 90,434	$ 84,322
3. Children 1 through 21 Years	$ 154,550	$ 171,301
4. CSHCN	$ 123,992	$ 126,022
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 459,410	$ 465,967
Federal State MCH Block Grant Partnership Total	$ 891,293	$ 897,137

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 24 Application Budgeted	FY 22 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	$ 238,082	$ 241,330
3. Public Health Services and Systems	$ 235,918	$ 231,957
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	$ 474,000	$ 473,287

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 409,910	$ 434,967
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 131,368	$ 137,644
B. Preventive and Primary Care Services for Children	$ 154,550	$ 171,301
C. Services for CSHCN	$ 123,992	$ 126,022
2. Enabling Services	$ 0	$ 0
3. Public Health Services and Systems	$ 49,500	$ 31,000
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 384,889
Dental Care (Does Not Include Orthodontic Services)		$ 50,078
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 434,967
Non-Federal Total	$ 459,410	$ 465,967

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: 472 **Data Source Year: 2022**

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	472 (100.0%)	11	10	10 (100.0%)

Program Name(s)				
Biotinidase Deficiency	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism
Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	X-Linked Adrenoleukodystrophy		

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The MCH and CSHCN Program have implemented and Inter-Agency Agreement between the CNMI Public School System (PSS) Part C of the DIEA and the Commonwealth Healthcare Corporation to provide services to infants and toddlers (birth to three years) who have been identified as having a disability and who would then be enrolled into the Early Intervention Services (EIS) Program.

While enrolled in EIS, services such as speech therapy, special instruction, physical therapy, vision, hearing, and psychological services are rendered and provided to families at no cost. Children identified as having a disability at birth and have surpassed the age of three years are transitioned into the Early Childhood Program that provides services to children ages three years to five years old. Children above the age of five years are transitioned into the Special Education Program under PSS where they will continue to receive on going service coordination.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2022**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: The data represents the total number of live births in the CNMI as reported by the CNMI Health & Vital Statistics Office (HVSO).	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2022**
	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:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: Total number screened through Newborn Screening. 472 - Newborn Hearing Screening 473 - Newborn Bloodspot Screening	
4.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: 3 - Newborn Hearing Screening 8 - Newborn Bloodspot Screening	
5.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: 2 - Newborn Hearing Screening 8 - Newborn Bloodspot Screening	

6.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**

Field Note:
2 - Newborn Hearing Screening
8 - Newborn Bloodspot Screening

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 2022

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	465	73.3	0.0	14.0	12.7	0.0
2. Infants < 1 Year of Age	473	73.6	0.0	13.9	12.5	0.0
3. Children 1 through 21 Years of Age	7,268	50.6	32.0	12.6	4.8	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,221	0.0	0.0	0.0	0.0	100.0
4. Others	9,633	74.6	0.0	22.2	3.2	0.0
Total	17,839					

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	570	No	465	100.0	465	465
2. Infants < 1 Year of Age	571	No	473	100.0	473	473
3. Children 1 through 21 Years of Age	18,188	No	7,268	100.0	7,268	7,268
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,384	No	1,221	100.0	1,221	1,221
4. Others	32,699	No	9,633	100.0	9,633	9,633

^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:	**2022**
	Field Note: Number of pregnant women who delivered their babies at CHCC during year 2022. (Data source - Health and Vital Statistics)	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: Number of babies delivered at CHCC during year 2022. (Data Source - Health and Vital Statistics)	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Number of Children 1 through 21 yeas of age who received health service at CHCC. (Data Source - CHCC, CareVue EHR).	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Number of Children with Special Health Care Needs (CSHCN) ages 0 through 21 yeas of age who are enrolled at Early Intervention (EI) and Special Education (SPED) during 2022. (Data Source - EI and SPED).	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**
	Field Note: Number of Females ages 22 years and older who received health care services at CHCC during year 2022. (Data source - CareVue EHR).	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**
	Field Note: Percentage of pregnant women served at CHCC during 2022.	
2.	**Field Name:**	**Pregnant Women Denominator**

	Fiscal Year:	**2022**
	Field Note: Denominator represents the total number of pregnant women who delivered babies at CHCC during year 2022. (Data Source - Health and Vital Statistics)	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: Percentage of infants < 1 year of age served at CHCC during year 2022.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: Denominator represents the total number of live births at CHCC during year 2022 (Data Source - Health and Vital Statistics)	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Percentage of population served at CHCC during year 2022. (Data source: CareVue EHR)	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2022**
	Field Note: Number of children ages 1 through 21 years of age seen at CHCC during 2022 (Data Source: CareVue EHR)	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Percentage of Children with Special Health Care Needs 0 through 21 years of age enrolled in Early Intervention services and SPED programs in the CNMI. The CNMI Title V Block Grant program supports the CNMI healthcare system with workforce capacity building, policy development, and data capacity efforts. The CHCC operates the only hospital and health emergency departments in the CNMI. (Data Sources: Early Intervention and Special Education Programs)	
8.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Denominator**
	Fiscal Year:	**2022**

	Field Note: Total number of children enrolled in Special Education and Early Intervention in year 2022. Data Source: SPED and EI dataset	
9.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	Field Note: Percentage of females ages 22 years and older who received health care services at CHCC during year 2022.(Data Source: CHCC CareVue EHR)	
10.	**Field Name:**	**Others Denominator**
	Fiscal Year:	**2022**
	Field Note: Others represent Females ages 22 years and older who received health care services at CHCC during 2022. Data Source: CareVue EHR	

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 1 through 21 Years of Age Denominator is less than or equal to 90% of the Children 1 through 21 Years of Age Reference Data. Please double check and justify with a field note.
4.	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.
5.	Others Denominator is less than or equal to 90% of the Others Reference Data. Please double check and justify with a field note.
6.	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.
7.	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.
8.	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.
9.	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.
10.	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.
11.	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 2022

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	465	6	0	0	0	150	236	69	4
Title V Served	465	6	0	0	0	150	236	69	4
Eligible for Title XIX	341	3	0	0	0	90	187	57	4
2. Total Infants in State	473	6	0	0	0	153	240	70	4
Title V Served	473	6	0	0	0	153	240	70	4
Eligible for Title XIX	348	3	0	0	0	93	190	58	4

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Number represents the total number of women with live births in year 2022. Data Source: CHCC Health and Vital Statistics	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Number represents the number of women who were served by Title V. Data Source: CHCC Health and Vital Statics	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Number represents the total number of women with live births who were eligible for Title XIX in year 2022. Data Source: CHCC Health and Vital Statistics	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Number represents the total number live births in year 2022. Data Source: CHCC Health and Vital Statistics	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Number represents the number of infants who were served by Title V. Data Source: CHCC Health and Vital Statics	

6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**

Field Note:
Number represents the total number of infants who were eligible for Title XIX in year 2022.
Data Source: CHCC Health and Vital Statistics

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

State: Northern Mariana Islands

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(670) 287-7718	(670) 287-7718
2. State MCH Toll-Free "Hotline" Name	MICAH Services	MICAH 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"		1,008

B. Other Appropriate Methods	2024 Application Year	2022 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		173
5. State Title V Social Media Websites	https://www.facebook.com/cnmipublichealth	https://www.facebook.com/cnmipublichealth
6. Number of Hits to the State Title V Program Social Media Websites		242,525

Form Notes for Form 7:

Data on social media website hits is based on the total number of daily unique users to the Division of Public Health'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. This data is based on FY2022.

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 Public Health Services
Address 1	1178 Hinemlu St
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 236-8711
Extension	
Email	heather.pangelinan@chcc.health

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Shiella Deray
Title	CYSHCN Program Manager
Address 1	1178 Hinemlu St
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 236-8711
Extension	
Email	shiella.deray@chcc.health

3. State Family Leader (Optional)	
Name	Chrislaine Manibusan
Title	Family Peer Support Specialist
Address 1	1178 Hinemlu St.
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 664-8700
Extension	
Email	chrislaine.manibusan@chcc.health

4. State 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 2024

No.	Priority Need
1.	Ability to find and see a doctor when needed (access to health services)
2.	Education and support to help with breastfeeding.
3.	Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care
4.	Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity
5.	Coping skills and suicide prevention
6.	Helping parents/caregivers navigate the health care system for coordinated care
7.	Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful.
8.	Professionals have the knowledge and skills to address the needs of maternal and child health populations

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Access to health services- ability to find and see a doctor when needed.	New
2.	Education and support to help with breastfeeding.	Revised
3.	Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care	Revised
4.	Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity	New
5.	Coping skills and suicide prevention	Revised
6.	Helping parents/caregivers navigate the health care system for coordinated care	New
7.	Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful	New
8.	Professionals have the knowledge and skills to address the needs of maternal and child health populations	New

Form 10
National Outcome Measures (NOMs)

State: Northern Mariana Islands

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

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
2021	68.8 %	1.9 %	391	568
2020	56.7 %	2.0 %	356	628
2019	49.9 %	1.9 %	338	677
2018	49.4 %	2.1 %	278	563
2017	52.2 %	2.6 %	188	360
2016	41.9 %	2.4 %	173	413
2015	39.7 %	2.4 %	167	421
2014	53.9 %	2.2 %	269	499
2013	46.4 %	2.1 %	275	593
2012	43.6 %	1.8 %	319	731
2011	60.7 %	4.1 %	88	145
2010	48.3 %	1.9 %	332	687

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	98.3 %	1.7 %	1,972	2,007
2019	77.0 % ϟ	10.0 % ϟ	1,252 ϟ	1,627 ϟ

Legends:

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

State Provided Data	
	2022
Annual Indicator	61.5
Numerator	291
Denominator	473
Data Source	CNMI Health and Vital Statistics
Data Source Year	2022

NOM 1 - Notes:

Data Source: CHCC Health and Vital Statistics.

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	
	2022
Annual Indicator	253.7
Numerator	12
Denominator	473
Data Source	CNMI HEALTH AND VITAL STATISTICS
Data Source Year	2022

NOM 2 - Notes:

Severe Maternal Morbidity - Numerator indicates the number of deliveries with diagnosis or procedure ICD-10 code for maternal transfusion, hypertension eclampsia, unplanned hysterectomy, admission to ICU, ruptured uterus and/or unplanned OR procedure.
Denominator indicates the number of live births.
Data Source: CHCC Health and Vital Statistics.

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**
2017_2021	NR	NR	NR	NR
2016_2020	NR	NR	NR	NR
2015_2019	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	473
Data Source	CHCC HEALTH AND VITAL STATISTICS
Data Source Year	2022

NOM 3 - Notes:

Zero maternal mortality recorded in year 2022.

Data Source: CHCC Health and Vital Statistics.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 3. Please review your data to ensure this is correct.

NOM 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
2021	8.1 %	1.1 %	46	570
2020	10.7 %	1.2 %	67	628
2019	7.1 %	1.0 %	48	679
2018	10.9 %	1.3 %	61	561
2017	7.6 %	1.4 %	27	356
2016	7.8 %	1.3 %	32	411
2015	7.8 %	1.3 %	33	424
2014	7.6 %	1.2 %	39	516
2013	7.8 %	1.0 %	53	677
2012	6.4 %	0.8 %	54	847
2011	7.3 %	0.8 %	75	1,032
2010	7.2 %	1.1 %	42	580
2009	8.6 %	0.8 %	95	1,107

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	13.3 %	2.5 %	2,277	17,149
2019	10.8 %	2.0 %	1,856	17,149

Legends:

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

State Provided Data	
	2022
Annual Indicator	10.8
Numerator	51
Denominator	473
Data Source	CHCC HEALTH AND VITAL STATISTICS
Data Source Year	2022

NOM 4 - Notes:

Numerator: Number of live births weighing < 2500g
Denominator: Total number of live births

Data Source: CHCC Health and Vital Statistics.

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**
2021	9.0 %	1.2 %	51	568
2020	10.7 %	1.2 %	67	628
2019	8.7 %	1.1 %	59	682
2018	10.4 %	1.3 %	59	565
2017	7.8 %	1.4 %	28	359
2016	12.1 %	1.6 %	50	412
2015	9.7 %	1.4 %	41	424
2014	9.3 %	1.3 %	48	517
2013	9.8 %	1.2 %	65	665
2012	7.6 %	0.9 %	62	813
2011	6.8 %	0.8 %	70	1,028
2010	7.6 %	0.8 %	78	1,023
2009	8.2 %	0.8 %	90	1,100

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	15.5 %	2.2 %	2,666	17,149
2019	14.2 %	3.2 %	2,431	17,149

Legends:

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

State Provided Data	
	2022
Annual Indicator	12.3
Numerator	58
Denominator	473
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 5 - Notes:

Numerator: Number of live births < 37 weeks of complete gestation
Denominator: Number of live births

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**
2021	29.2 %	1.9 %	166	568
2020	28.3 %	1.8 %	178	628
2019	28.0 %	1.7 %	191	682
2018	30.6 %	1.9 %	173	565
2017	33.4 %	2.5 %	120	359
2016	27.2 %	2.2 %	112	412
2015	28.8 %	2.2 %	122	424
2014	28.6 %	2.0 %	148	517
2013	31.1 %	1.8 %	207	665
2012	28.2 %	1.6 %	229	813
2011	28.0 %	1.4 %	288	1,028
2010	22.6 %	1.3 %	231	1,023
2009	28.4 %	1.4 %	312	1,100

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data	
	2022
Annual Indicator	27.9
Numerator	132
Denominator	473
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 6 - Notes:

Numerator Number of live births born at 37,38 weeks
Denominator: Number of live births

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	
	2022
Annual Indicator	16.7
Numerator	8
Denominator	479
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 8 - Notes:

Numerator: Number of fetal deaths 28 weeks or more gestation plus early neonatal deaths

Denominator: Number of live births plus fetal deaths

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**
2021	NR	NR	NR	NR
2019				
2018				
2018				
2017				
2016				
2015				
2014				
2013				
2012				
2011				
2010				
2009				

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2022
Annual Indicator	12.7
Numerator	6
Denominator	473
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 9.1 - Notes:

Numerator: Number of deaths to infants from birth through 364 days of age
Denominator: Number of Live births

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**
2021	NR	NR	NR	NR
2019				
2018				
2018				
2017				
2016				
2015				
2014				
2013				
2012				
2011				
2010				
2009				

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2022
Annual Indicator	4.2
Numerator	2
Denominator	473
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 9.2 - Notes:

NUMERATOR: Number of deaths to infants under 28 days

DENOMINATOR: Number of live births

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**
2021	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2022
Annual Indicator	8.5
Numerator	4
Denominator	473
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

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	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	473
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 9.4 - Notes:

No Preterm-related deaths occurred in 2022

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 9.4. Please review your data to ensure this is correct.

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**
2021	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 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	
	2022
Annual Indicator	1.1
Numerator	5
Denominator	473
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 10 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	473
Data Source	HVSO
Data Source Year	2022

NOM 11 - Notes:

No neonatal abstinence syndrome case was identified in 2022 live birth dataset.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 11. Please review your data to ensure this is correct.

NOM 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
2019	13.0 %	3.0 %	2,138	16,434

Legends:

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

NOM 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**
2021	NR	NR	NR	NR
2020	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2022
Annual Indicator	30.4
Numerator	2
Denominator	6,580
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 15 - Notes:

Numerator represents the number of deaths among children ages 1 through 9 year.
Data source: Health and Vital Statistics

Denominator represents the number of children ages 1 through 9 years
Data Source: (International Database Estimate, U.S. 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**
2021	NR	NR	NR	NR
2020	NR	NR	NR	NR
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2022
Annual Indicator	31.4
Numerator	3
Denominator	9,563
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 16.1 - Notes:

Numerator - Number of deaths among adolescents ages 10 through 19 years
Data source: (HVSO)

Denominator: Number of adolescents ages 10 through 19 years (International Database Estimate, U.S. Census)

Data Alerts: None

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**
2019_2021	NR	NR	NR	NR
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
2008_2010	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2022
Annual Indicator	40.8
Numerator	2
Denominator	4,902
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 16.2 - Notes:

Numerator - Number of deaths to adolescents ages 15 through 19 years caused by motor vehicle crashes. Data Source: CHCC HVSO

Denominator - Number of adolescents in the State ages 15 through 19 years
(International Database Estimate, U.S. Census)

Data Alerts: None

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**
2019_2021	NR	NR	NR	NR
2018_2020	NR	NR	NR	NR
2017_2019	NR	NR	NR	NR
2016_2018	NR	NR	NR	NR
2015_2017	NR	NR	NR	NR
2014_2016	NR	NR	NR	NR
2013_2015	NR	NR	NR	NR
2012_2014	NR	NR	NR	NR
2011_2013	NR	NR	NR	NR
2010_2012	NR	NR	NR	NR
2009_2011	NR	NR	NR	NR
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	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	4,902
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 16.3 - Notes:

Numerator - Number of deaths attributed to suicide among youths ages 15 through 19 years. (Zero suicide deaths) Data Source: HVSO

Denominator Number of adolescents ages 15 through 19 years
(International Database Estimates, U.S. 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
2019	6.2 %	1.4 %	1,059	17,149

Legends:

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

NOM 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

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	0 %	0	0	1,252
2019	2.6 %	2.6 %	28	1,059

Legends:

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

NOM 17.2 - Notes:

None

Data Alerts: None

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
2019	2.4 %	1.0 %	343	14,237

Legends:

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

NOM 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
2019	2.1 %	0.9 %	302	14,237

Legends:

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

NOM 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
2019	21.2 %	14.2 %	101	476

Legends:

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

NOM 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
2019	81.2 %	3.3 %	13,920	17,149

Legends:

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

NOM 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
2020	9.3 %	0.9 %	102	1,095
2018	8.7 %	0.7 %	136	1,569
2016	7.8 %	0.7 %	111	1,418
2014	9.0 %	0.7 %	162	1,808
2012	11.3 %	0.7 %	253	2,239
2010	14.1 %	0.8 %	304	2,157

Legends:

Indicator has a denominator <20 and is not reportable

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	23.4 %	0.9 %	645	2,761
2019	21.6 %	0.8 %	627	2,900
2017	16.4 %	0.8 %	508	3,091
2015	16.0 %	0.7 %	495	3,096
2013	15.8 %	0.7 %	481	3,036
2011	13.5 %	0.7 %	438	3,247
2007	14.3 %	0.7 %	375	2,625
2005	16.5 %	0.7 %	482	2,923

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

Data Source: MCH Jurisdictional Survey (MCH-JS) - Age 10-17

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	24.1 %	4.2 %	1,857	7,709
2019	17.5 %	4.3 %	1,347	7,709

Legends:

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

NOM 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
2019	21.5 %	2.5 %	3,689	17,149

Legends:

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

State Provided Data	
	2022
Annual Indicator	1.8
Numerator	
Denominator	
Data Source	
Data Source Year	

NOM 21 - Notes:

Numerator - Number of children ages 0 through 17 who were seen at CHCC and were not currently covered by any private or public health insurance. (Data Source: CHCC EHR)

Denominator - Number of children ages 0 through 17
(International Database Estimates, U.S. Census)

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	
	2022
Annual Indicator	69.3
Numerator	1,126
Denominator	1,624
Data Source	CHCC WebIZ
Data Source Year	2022

NOM 22.1 - Notes:

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

Denominator Number of children, ages 19 through 35 months

Both numerator and denominator are based on data obtained from the CNMI Immunization Information System (WebIz).

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	
	2022
Annual Indicator	73.4
Numerator	12,467
Denominator	16,979
Data Source	CNMI Webiz, IIS
Data Source Year	2022-2023

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

Data source for both numerator and denominator values are obtained from the CNMI Immunization Information System (Webiz).

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	
	2022
Annual Indicator	96.6
Numerator	5,192
Denominator	5,372
Data Source	CHCC WebIZ
Data Source Year	2022

NOM 22.3 - Notes:

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

Denominator Number of adolescents, ages 13 through17 years

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	
	2022
Annual Indicator	99.5
Numerator	5,347
Denominator	5,372
Data Source	CHCC WebIZ
Data Source Year	2022

NOM 22.4 - Notes:

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

Denominator Number of adolescents, ages 13 through17 years

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	
	2022
Annual Indicator	98.3
Numerator	5,280
Denominator	5,372
Data Source	CHCC WebIZ
Data Source Year	2022

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

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**
2021	14.0	2.6	30	2,147
2020	17.9	2.9	38	2,126
2019	20.6	3.1	43	2,091
2018	28.3	3.7	58	2,048
2017	16.1	2.8	33	2,052
2016	27.4	3.7	56	2,047
2015	28.2	3.8	56	1,988
2014	29.6	3.9	59	1,992
2013	35.6	4.2	71	1,996
2012	33.1	4.1	66	1,996
2011	46.3	4.9	90	1,944
2010	57.0	5.4	112	1,965
2009	49.8	4.9	103	2,069

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2022
Annual Indicator	9.9
Numerator	22
Denominator	2,224
Data Source	CHCC Health and Vital Statistics
Data Source Year	2022

NOM 23 - Notes:

Numerator: Number of births to adolescents, ages 15 through 19 years
Data Source: (CHCC Health and Vital Statistics)
Denominator: Number of adolescent females, ages 15 through 19 years
Data Source: (International Database Estimates, U.S. Census 2022)

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 %	10.6 %	678	2,007
2019	56.5 %	12.3 %	919	1,627

Legends:

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

NOM 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
2019	6.1 %	1.9 %	1,045	17,149

Legends:

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

NOM 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**	**2022**
Annual Objective		56	59	59
Annual Indicator	55.5	55.5	57.1	57.1
Numerator	6,544	6,544	7,415	7,415
Denominator	11,784	11,784	12,993	12,993
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	19	20	56	57	59
Annual Indicator	20.5	22.7	25.4	65.4	
Numerator	1,587	1,757	1,959	5,047	
Denominator	7,732	7,742	7,721	7,717	
Data Source	CNMI EHR Pap Exam, International database estimate	CNMI EHR Pap Exam, International database estimate	CHCC Preventive Visits and US international census	CHCC EHR/RPMS Preventive visits	
Data Source Year	2018	2019	2020	2021	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

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

Field Level Notes for Form 10 NPMs:

1.	**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.	
2.	**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	
3.	**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**	**2022**
Annual Objective	96	97	98	98
Annual Indicator	74.2	74.2	88.2	88.2
Numerator	4,288	4,288	5,434	5,434
Denominator	5,776	5,776	6,158	6,158
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	96	96	97	97	98
Annual Indicator	95.8	96.5	93.3	93.7	94.9
Numerator	1,209	877	610	539	449
Denominator	1,262	909	654	575	473
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	2018	2019	2020	2021	20
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

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

Field Level Notes for Form 10 NPMs:

1.	**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.	
2.	**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	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of infants who were reported by their parents to have been breastfed after birth or prior to discharge at CHCC. Denominator: 2022 HVSO Live birth dataset	

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

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

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	4	4	5	5	6
Annual Indicator	2.5	1.1	0.4	0	0.5
Numerator	12	5	2	0	2
Denominator	486	470	544	419	411
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6.0	7.0	7.0

Field Level Notes for Form 10 NPMs:

1.	**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.	
2.	**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.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of 6 month old infants enrolled in the WIC program who were breastfed exclusively for 6 months. Denominator: Number of 6 month old infants enrolled in the WIC program.	

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**	**2022**
Annual Objective			57	57
Annual Indicator	52.7	52.7	43.5	43.5
Numerator	2,769	2,769	2,393	2,393
Denominator	5,253	5,253	5,498	5,498
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019	2021	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			46	46
Annual Indicator	42.4	42.4	39.3	39.3
Numerator	2,593	2,593	2,156	2,156
Denominator	6,119	6,119	5,493	5,493
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

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

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year. Data Source: RPMS and New CareVue EHR Denominator Number of adolescents, ages 12 through 17 Data source: International Database Estimate, US CENSUS	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of adolescents, ages 12 through 17, with a preventive medical visit in the past year at the CHCC. Data Source: New CareVue EHR Denominator Number of adolescents, ages 12 through 17 Data source: International Database Estimate, US CENSUS	

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**	**2022**
Annual Objective	20	15	15	15
Annual Indicator	13.3	13.3	14.1	14.1
Numerator	141	141	176	176
Denominator	1,059	1,059	1,252	1,252
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	49	20	15	19	15
Annual Indicator	19.6	19.6			
Numerator	54	54			
Denominator	276	276			
Data Source	CSHCN Survey	CSHCN Survey			
Data Source Year	2018	2019			
Provisional or Final ?	Provisional	Provisional	Provisional		

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

Field Level Notes for Form 10 NPMs:

1.	**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.	
2.	**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**	**2022**
Annual Objective			55	55
Annual Indicator	51.0	51.0	32.8	32.8
Numerator	183	183	167	167
Denominator	358	358	511	511
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	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**	**2022**
Annual Objective			52	52
Annual Indicator	48.4	48.4	46.3	46.3
Numerator	2,788	2,788	2,306	2,306
Denominator	5,761	5,761	4,982	4,982
Data Source	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN
Data Source Year	2019	2019	2021	2021

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	47	49	51	53	70
Annual Indicator	48.3	48.8	55.6	66.8	61.7
Numerator	329	340	351	382	290
Denominator	681	697	631	572	470
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of deliveries to resident women receiving prenatal care beginning in the first trimester of pregnancy. Denominator: Number of deliveries to resident women in year 2022.	

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	15
Annual Indicator			2.1	34
Numerator			2	32
Denominator			94	94
Data Source			CHCC HUMAN RESOURCES	CHCC HUMAN RESOURCES
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	25.0	30.0

Field Level Notes for Form 10 SPMs:

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

Field Note:
Numerator: 2 MICAH employees received training on using / entering data into the new electronic health record (CareVue) revenue cycle management (RCM) that was conducted in year 2021, however, due to the challenges presented by COVID-19 pandemic, development of instructional methods to administer training across CHCC PHS staff and MCH serving professionals was postponed to a later date.

Denominator: Number of PHS and MICAH employees

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Numerator: 3 individuals from PHS and 1 person from MCH attended SAS analytic training conducted by CHCC Epidemiologist; 1 employee attended Power BI training in year 2022; 6 attended one key question training; 21 attended breastfeeding bootcamp. Total 32 training participants in 2022.

Other training opportunities were interrupted due to COVID-19 pandemic.

Discussion for providing standardized curriculum for online training to Population Health Staffs including MCH Professionals are ongoing.

Denominator: Number of CHCC PHS and MCH staff and employees.

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 all CHCC health service sites.

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	53.0	55.0	57.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of females ages 18-44 who received preventive care services at CHCC sites Denominator: Number of women ages 18-44 years (International Database Estimates; U.S. Census)	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of females ages 18-44 who received preventive care services at CHCC sites Denominator: Number of women ages 18-44 years (International Database Estimates; U.S. Census)	

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	57.4
Annual Indicator			44.6	39.9
Numerator			187	164
Denominator			419	411
Data Source			WIC Program	WIC Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	57.6	57.8	58.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of WIC enrolled infants who were breastfed at 6 months. Denominator: Total number of 6 month old infants in the WIC Program	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of WIC enrolled infants who were breastfed at 6 months. Denominator: Total number of 6 month old infants in the WIC Program	

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	2022
Annual Objective			10	15
Annual Indicator			0	0
Numerator			0	0
Denominator			3	8
Data Source			MCH referral log and EFNEP enrollment record	MCH referral log and EFNEP enrollment record
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	25.0	30.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of referrals who reported completing at least 75% of the EFNEP program curriculum. Denominator: Number of referrals to the EFNEP program	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of referrals who reported completing at least 75% of the EFNEP program curriculum. Denominator: Number of referrals to the EFNEP program	

ESM 10.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	12.5	13.0	13.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator- Number of teens ages 12 through 17 years who accessed preventive care at CHCC sites. Denominator- Number of teens ages 12 through 17 years (US Census International Database Estimate)	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator- Number of teens ages 12 through 17 years who accessed preventive care at CHCC sites. Denominator- Number of teens ages 12 through 17 years (US Census International Database Estimate)	

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	2022
Annual Objective			10	20
Annual Indicator			81	0
Numerator			51	0
Denominator			63	63
Data Source			F2F Medical Home Survey	F2F Medical Home Survey
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	30.0	40.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of families served by the Family to Family Health Information Center who reported having a medical home. Denominator: Number of families served by Family to Family Health Information Center.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The COVID-19 pandemic (2021-2022) disrupted the implementation of F2F Medical Home Survey. The survey will resume in year 2023.	

ESM 12.1 - Percentage of high school students served by SPED who received information on transition

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	15
Annual Indicator			0	5.8
Numerator			0	16
Denominator			271	277
Data Source			Program Administrative Data/PSS SPED	Program Administrative Data/PSS SPED
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	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. Numerator: Number of high school teens in special education services who received information on transition services. Denominator: Number of high school teens in special education services.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of high school teens in special education services who received information on transition services. Denominator: Number of high school teens in special education services.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Northern Mariana Islands

SPM 1 - Percent of live births to resident women with first trimester prenatal care.
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of pregnant women with first trimester prenatal Care</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of live births by resident women with first trimester prenatal care.</td></tr>
<tr><td>Denominator:</td><td>Total number of live births by resident women.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CNMI Hospital records, CNMI HVSO data</td></tr>
<tr><td>Significance:</td><td>Early and adequate prenatal care is vital to ensuring a healthy pregnancy. Receiving inadequate prenatal care increases the risk for complications and other adverse outcomes for both mother and baby. Early and adequate prenatal care provides the opportunity for early detection and management of complications which reduces the risk for pre-term labor and babies being born with low birth weight. According to the 2015 CNMI MCH Needs Assessment, almost 70% of deliveries in 2013 received inadequate prenatal care and 6% received no prenatal care at all.</td></tr>
</table>

SPM 2 - Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	By 2025, increase the number of CHCC Public Health staff (PHS) and MCH serving professionals who complete training on MCH priorities and topics by 25% from baseline.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CHCC PHS staff and MCH serving professionals who completed training on MCH priorities and related topics. **Denominator:** Number of CHCC PHS staff and MCH serving professionals
Data Sources and Data Issues:	Health Department/CHCC Administrative Records.
Significance:	A skilled workforce is critical for rapidly changing and emerging public health issues. It is important for health department employees, especially those serving MCH populations, to posses the knowledge and skills to effectively work towards improving the health outcomes and life trajectories of the women and children we serve.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Northern Mariana Islands

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Northern Mariana Islands

ESM 1.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.
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 at CHCC **Denominator:** Number of women ages 18-44 years
Data Sources and Data Issues:	The data source: Numerator - CareVue EHR including those who all visited the CHCC health department/clinics, and MICAH internal and external partners during the past year. Denominator: - International Database, U.S. Census
Evidence-based/informed strategy:	ESM 1.1 measures the number of women ages 18-44 years who access preventive care visit at CHCC. Data source includes Electronic Health Record and Records of Outreach Events that provides information on activities involving expanding clinical hours, and utilization of the mobile clinic to improve access to health care service
Significance:	Evidence suggests that expanded hours increases access and provides opportunities for working women and others with schedule challenges to access care.

ESM 4.1 - Percentage of WIC 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 6 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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of referrals who reported completing at least 75% of the EFNEP program curriculum. **Denominator:** Number of referrals to the EFNEP program
Data Sources and Data Issues:	Data source: MCH Referral Logs
Evidence-based/informed strategy:	Referrals to an evidence-based nutrition and physical activity program (EFNEP) can be made during Well child visits at CHCC outpatient clinics (Children's Clinic, Mobile Clinic, RHC, THC) which supports an evidence-based Eating Smart Being Active curriculum that teaches children healthy lifestyle choices, nutrition, physical activity including food preparation.
Significance:	Medical providers play a critical role in obesity prevention through communicating early body mass index screening results to parents and helping them to adopt key behavioral changes in diet and physical activity. The well-child visit and evidence-based program on healthy eating and physical activities are essential at addressing obesity prevention,

ESM 10.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites
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 Providers 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 ages 12 through 17 who receive prevent care visit at CHCC sites</td></tr>
<tr><td>Denominator:</td><td>Total number adolescent ages 12-17 years.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Numerator: CareVue EHR
Denominator: International Database U.S. Census</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The ESM measures the the number of adolescent ages 12 through 17 years who access preventive care visits and allow providers to conduct behavioral/mental health screening, and assessment focused on improving the patient's health and well-being holistically.</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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families served by the Family to Family Health Information Center who reported having a medical home. **Denominator:** Number of families served by Family to Family Health Information Center.
Data Sources and Data Issues:	Data will be obtained through program administrative records/referral forms.
Evidence-based/informed strategy:	F2F Survey provide information on the number of clients who reported having having a medical home; F2F program provide support to reduce isolation, shame and blame, and assist parents in navigating child serving systems, including access to medical homes.
Significance:	Family Peer Support is the instrumental, social and informational support provided from one parent to another in an effort to reduce isolation, shame and blame, to assist parents in navigating child serving systems, including access to medical homes.

ESM 12.1 - Percentage of high school students served by SPED who received information on transition
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The goal is to utilize school based presentations to increase awareness and knowledge regarding the importance of and process of transition into adult healthcare.</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 high school students served by SPED who received information on transition</td></tr>
<tr><td>Denominator:</td><td>Number of high school students served by SPED</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CSHCN presentation dataset</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Number of adolescents and families who attended healthcare transition presentation that aims to enhance awareness to the importance of transition/referral to another provider, managing medical needs, and knowledge about health continuity.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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 2022

	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	No	Annually	12	No	
4) WIC	Yes	No	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	12	No	
6) Newborn Hearing Screening	Yes	Yes	Daily	1	Yes	
7) Hospital Discharge	Yes	Yes	Annually	12	No	
8) PRAMS or PRAMS-like	Yes	Yes	Daily	12	No	

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) Immunization	Yes	Yes	Quarterly	3	Yes	
10) YRBSS	Yes	Yes	Annually	12	No	
11) Family Planning Annual Report	Yes	Yes	Quarterly	3	No	
12) Non-Communicable Disease	Yes	Yes	Annually	12	No	
13) H.O.M.E. Visiting	Yes	Yes	Annually	12	No	
14) Communicable Disease	Yes	Yes	Annually	12	No	
15) Developmental Screening	Yes	Yes	Monthly	1	No	
16) Early Intervention Program	Yes	Yes	Annually	12	No	
17) Special Education Program	Yes	Yes	Annually	12	No	
18) Public School System	Yes	Yes	Annually	12	No	
19) MCH Jurisdictional Survey	Yes	Yes	Annually	25	No	
20) CHCC Dental/Oral Health Program	Yes	Yes	Annually	12	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None