Northern Mariana Islands — State Action Plan Table — 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Ability to find and see a doctor when needed (access to health services)	By 2025, increase the number of women who access preventive visits to 65%, an increase from the baseline of 55%	Expand access: Outreach and/ or Increased clinic hours. Conduct community awareness activities to promote women's preventive health visits.	ESM WWV.1 - Percentage of women ages 18 through 44 who reported accessing preventive services at all CHCC health service sites.	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per

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					1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive

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					symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD
Ability to find and see a doctor when needed (access to health services)	By 2025, the CNMI will determine the baseline number of women who attended a postpartum checkup within 12 weeks after giving birth and the percent of women who attended a postpartum checkup and received the recommended care components.	Utilize the CNMI PRAMS data to identify the baseline number of women completing postpartum checkups and the percentage receiving recommended care components.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through 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		SPM 1: Percent of live births to resident women with first trimester prenatal care.	
Education and support to help with breastfeeding.	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	ESM BF.1 - Percentage of WIC infants who were breastfed at 6 months.	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality,

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					Formerly NOM 9.5) - IM-SUID
Child Health					
Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity	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%.	Increase the number of families who enroll in and evidence nutrition and physical activity programs. Increase community awareness on the importance physical activity for children.	ESM PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP program curriculum.	NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child	NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS
Helping parents/caregivers navigate the health care system for coordinated care	By 2025, increase the percentage of CSHCN who report having a medical home to 13%, an increase from the baseline of 9% in 2023.	Partner with the CHCC Mobile Clinic to increase access to well child visits to connect children to medical homes.	ESM MH.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care,

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					Formerly NOM 25) - FHC
Adolescent Health					
Coping skills and suicide prevention	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 visits.	ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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					NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

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Helping parents/caregivers navigate the health care system for coordinated care	By 2025, increase the percentage of adolescents ages 12 through 17 years with and without special healthcare needs who receive transition services to 74% and 61%, respectively, an increase from baseline percentages of 51% and 48%, respectively.	Provide education, presentations, and support to high school students and/or their parents in making transition into adult healthcare.	ESM TR.1 - Percentage of high school students served by SPED who received information on transition	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
Children with Special Health Care Needs					
Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful.	By 2025, increase the percentage of CSHCN who report having a medical home to 25%, an increase from a baseline percentage of 13%.	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 MH.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Helping parents/caregivers	By 2025, increase the percentage of adolescents ages 12 through	Provide education, presentations, and support to high school students with special healthcare needs in making transition into adult healthcare.	ESM TR.1 - Percentage of high	NPM - Percent of adolescents with and	NOM - Percent of children with special health care needs

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navigate the health care system for coordinated care	17 years with and without special healthcare needs who receive transition services to 74% and 61%, respectively, an increase from baseline percentages of 51% and 48%, respectively.		school students served by SPED who received information on transition	without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	(CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
Cross-Cutting/Systems Building					
Professionals have the knowledge and skills to address the needs of maternal and child health populations	By 2025, increase the number of CHCC Public Health staff (PHS) who complete training on MCH priorities and topics by 25% from baseline.	Implement a learning management system to provide training and capture completion rates		SPM 2: Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics.	