Northern Mariana Islands — State Action Plan Table — 2027 Application/2025 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					
Access to preventative medical visits	By 2030, increase the percentage of women accessing preventive visits, including postpartum visits, by 5% from baseline.	Increase access to preventive medical visits, including postpartum, care by expanding mobile clinic and other clinical outreach activities.	ESM PPV.1 - Percentage of women (age 18+) who are accessing well woman visits, prenatal care visits, and postpartum visits via mobile clinic and other clinical outreach.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Access to Mental Health Services	By 2030, increase the percentage of postpartum women who are screened for depression and referred to services by 5% from baseline.	Strengthen universal maternal depression screening, referral, and follow-up systems across prenatal and postpartum care settings.	ESM MHS.1 - Number of maternal health clinics that participated in the assessment survey regarding maternal depression screenings.	NPM - Postpartum Mental Health Screening	**Linked NOMs:** Maternal Mortality Infant Mortality SUID Mortality Neonatal Abstinence Syndrome Child Injury Hospitalization Women's Health Status Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Education and services to help prevent premature births and low birthweight.	By 2030, increase the percentage of women receiving first trimester prenatal care by 10% from baseline.	Implement a coordinated prenatal care navigation and referral system to ensure pregnant women are connected to prenatal care as early as possible.	SPM ESM 1.1 - Assessment to identify groups or reasons for not accessing early prenatal care completed (Y/N).	SPM 1: Percent of CNMI resident women with live births who receive prenatal care beginning in the first trimester.	
Education and	By 2030, increase the percentage	Strengthen coordinated breastfeeding education, referral, and early	***Inactive -*** *ESM BF.1 -*	NPM - Breastfeeding	**Linked NOMs:**

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support to help with breastfeeding	of infants who were breastfed exclusively through 6 months by 5% from baseline.	postpartum support through existing maternal and child health programs.	*Percent of postpartum women who receive breastfeeding education, assessment, or referral during a postpartum or infant healthcare encounter within two weeks of delivery.* ESM BF.2 - Percent of postpartum women who receive breastfeeding education, assessment or a referral during a postpartum or infant healthcare encounter within 2 weeks of delivery.		Infant Mortality Postneonatal Mortality SUID Mortality
Education and support to help with breastfeeding	By September 2030, increase the proportion of WIC-enrolled infants who are breastfed through 6 months by 10 percentage points from the CNMI baseline, through strengthened postpartum breastfeeding support, lactation referral, and peer counseling.	Strengthen coordinated breastfeeding education, referral, and early postpartum support through existing maternal and child health programs.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: Percent of CNMI WIC infants breastfed at 6 months.	
Child Health					
Access to healthy physical activity	By 2030, increase the percentage of children ages 6-11 who are physically active by 5% from baseline.	Collaborate through the CNMI Physical Activity Council to increase opportunities for children ages 6–11 and their families to participate in safe, accessible, and community-based physical activity programs through coordinated outreach, education, and partnership activities.	***Inactive -*** *ESM PA-Child.1 - PA-Child.1 - Percentage of referrals by MCH who reported completing at least 75% of the EFNEP*	NPM - Physical Activity - Child	**Linked NOMs:** Children's Health Status Child Obesity

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			program curriculum. ESM PA-Child.2 - Percent of children ages 6-11 years who enroll in after school sports or other group activities. ESM PA-Child.3 - Number of collaborative physical activity initiatives or events supported by the MCH Program through the CNMI Physical Activity Council that engage children ages 6–11 and their families.		
Access to care coordination and navigation of healthcare and community programs	By 2030, increase the percentage of CNMI children ages 6-11 who report having a medical home by 5%.	Strengthen access to a medical home for children and youth, including children with special healthcare needs by providing training and technical assistance to pediatric primary care clinics and providers on implementing medical home principles and related policies.	***Inactive -*** *ESM MH.1 - Number of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).* ESM MH.2 - Percent of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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Adolescent Health					
Access to teen pregnancy and sexually transmitted infection prevention programs	By 2030, decrease the rate of sexually transmitted infections (STIs) and teen births among adolescents aged 12 to 17 years by 5% from baseline.	Partner with the Public School System to expand access to adolescent well-visits and the Family Planning program. Increase awareness of adolescent well-visits and confidential services through conducting PATCH for Peer Workshops.	***Inactive -*** *ESM AWV.1 - Percentage of adolescents ages 12 through 17 years who access preventive care visit at all CHCC sites* ESM AWV.2 - Percentage of Public School System (PSS) high school students who participate in school-based health services. ESM AWV.3 - Number of teens who completed the PATCH Peer-to-Peer Workshops in the past year.	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Bullying prevention and support	By 2030, decrease the rate of high school students who experienced bullying on school property by 5% from baseline.	Collaborate with the Public and Private School Systems to assess bullying prevention needs and utilize survey feedback to identify gaps, strengthen implementation of existing evidence-based bullying prevention programs, and provide targeted support, training, and resources to improve student well-being and school safety.	ESM BLY.1 - Percent of schools participating in bullying prevention needs assessment and planning activities.	NPM - Bullying	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Adolescent Depression/Anxiety Adverse Childhood Experiences
Children with Special Health Care Needs					
Access to care coordination and navigation of healthcare and community programs	By 2030, increase the percentage of CNMI CSHCN ages who report having a medical home by 5%.	Strengthen access to a medical home for children and youth, including children with special healthcare needs by providing training and technical assistance to pediatric primary care clinics and providers on implementing medical home principles and related policies.	***Inactive -*** *ESM MH.1 - Number of pediatric providers who received medical home training and implemented at least*	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN

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			one component (e.g., care coordination, family engagement, team-based care). ESM MH.2 - Percent of pediatric providers who received medical home training and implemented at least one component (e.g., care coordination, family engagement, team-based care).		Flourishing - Child Adolescent - All
Parent training to support Transition from pediatric to adult healthcare	By 2030, increase the percent of parents of CSHCN who receive training on transition into adult care by 10% from baseline.	Provide training on transition planning to help families prepare for the shift from pediatric to adult systems.	***Inactive -*** *ESM TAHC.1 - Percentage of high school students served by SPED who received information on transition* ESM TAHC.2 - Percent of parents who complete transition training.	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care
Cross-Cutting/Systems Building					
Clear communication about health services and supports available for MCH populations	By 2030, develop and implement a centralized, user friendly digital platform that serves as a resource hub for health and wellness resources for all MCH population health domains.	Conduct user experience (UX) research with MCH populations (e.g., surveys, focus groups) to guide the design and content structure of the digital platform.	SPM ESM 2.1 - User research (i.e. surveys and focus groups) completed.	SPM 2: Percent of progress milestones completed toward the development and implementation of a centralized, user-friendly digital platform.	