Maternal and Child Health Services Title V Block Grant

Northern Mariana Islands

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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

CEO-L21-0857

August 26, 2021

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

Subject: HRSA Announcement No. HRSA-22-001/ Tracking No. 189356

Dear Mr. Dykton,

The Commonwealth of the Northern Mariana Islands' Commonwealth Healthcare Corporation (CNMI-CHCC) is pleased to submit the FY 2022 Title V Block Grant Application / 2020 Annual Report.

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

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

Sincerely,

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

II. Logic Model

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

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

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

MCH DOMAIN	MCH PRIORITY	PERFORMANCE MEASURE
Women's/Maternal Health	Access to health services-ability to find and see a doctor when needed	NPM 1: Well-woman/preventive visits
Perinatal/Infant Health	Breastfeeding education & support	NPM 4: Breastfeeding
	Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care	SPM 1: Prenatal care
Child Health	Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity	NPM 8: Physical Activity
Adolescent Health	Coping skills and suicide prevention	NPM 10: Adolescent Well-Visits
CSHCN	Helping parents/caregivers navigate the health care system for coordinated care	NPM 11: Medical Homes
Adolescent Health & CSHCN	Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful	NPM 12: Transition
Systems Building	Professionals have the knowledge and skills to address the needs of maternal and child health populations	SPM 2: MCH Capacity Building

CNMI MCH leadership developed a state action plan with specific objectives and strategies to address the nine 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, shows room for improvement based on the data of only 43.2% of women being up to date with pap testing, and was ranked high for feasibility and impact as well as program capacity to affect change. Additionally, an MCH survey conducted in 2020 indicated that just 55% of women ages 18-44 years reported completing an annual preventive visit. Public input data suggested that screening for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues would be integrated into the women/maternal health visits to respond to this identified need. This priority aligns with National Performance Measure (NPM) #1- Well-woman visit.

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

National Performance Measure 1: Percentage of women ages 18-44 years with a past year preventive visit.

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

Strategy: Expand access: Outreach and/ or Increased clinic hours.

INFANT HEALTH

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) were combined into the above priority for which MCH has program capacity to affect change. This combined priority ranked high for feasibility and impact. Data supports this priority with first trimester prenatal care at 55% and infant mortality at 7.6 per 1,000 live births in 2020. Because CNMI does not have a level III neonatal intensive care unit, this priority will be a State Performance Measure (SPM) evaluated by prenatal care.

Priority Need: Breastfeeding

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

Objective: By 2025, increase of the number of infants breastfed through 6 months to 54%, an increase of 10% from baseline.

Strategy: Implement workplace breastfeeding policies/support

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

State Performance Measure 1: Percent of prenatal women with first trimester prenatal care.

Objective: By 2025, increase the number of pregnant women with first trimester prenatal Care to 65%, an increase of 10% from baseline.

Strategy: Provide service navigation for pregnant women.

CHILD HEALTH

The top three public input priorities were combined into an overarching priority: 1. information and support to help children reach and stay at a healthy weight [obesity]; 2. information and support about healthy eating options and how to make sure a family has enough food [nutrition/food security]; and 3. safe schools and neighborhood programs, were combined into the priority “Obesity related issues including nutrition and physical activity.” The overall economics of the CNMI population makes food security and nutrition for children an explicit issue. YRBS data shows that less than half of students eat breakfast every day. It is known that expensive nutrition rich foods are replaced with high-calorie, high-fat, high-sodium options. In addition, 31.5% of the public does not believe children of the CNMI have access to healthy physical activities. YRBS activity data shows that only half the students played at least one sport in the past year. The WIC data for 2- to 5-year-olds from 2016 through 2018 shows an increase in obesity/overweight with 10.1% of children in the program being obese and 21.8% being overweight. In addition, an increasing number of middle school students, 31%, self-report being

overweight. Although nutrition/ food security and obesity was ranked high for feasibility and impact as well as program capacity to affect change, safe schools and neighborhood programs was not. Although MCH 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. Additionally, 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 is an important place to address obesity prevention given the influential role of pediatric primary care providers and their regular contact with families during well-child visits.

Priority Need: Obesity related issues including nutrition and physical activity

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

Objective: By 2025, increase the number of children ages 6 through 11 years who report being active at least 60 minutes a day to 63%, an increase of 10% from baseline.

Strategies:

1. Increase the number of children accessing well-child visits.

2. Provide information and resources for parents and caregivers to promote physical activity for children ages 6 through 11 years.

ADOLESCENT HEALTH

It was determined that screening for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues would be integrated into the adolescent health visits to response to this identified need. Both the original and the adolescent specific surveys showed that coping skills, suicide prevention and mental and behavioral health in general are of utmost importance. In addition, YRBS data shows an increase in suicidal thoughts among teens. Suicide prevention was also ranked high for feasibility and impact as well as program capacity to affect change. This priority aligns with NPM #10- Adolescent well-visit. MCH intends to promote well visits for adolescents using a holistic approach including promoting coping skills and preventing suicide as part of a behavioral health screening and assessment to be conducted at the well-visit.

Priority Need: Coping Skills and Suicide Prevention

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

Objective: By 2025, increase the number of adolescents who access well visits to 55%, an increase of 13% from baseline.

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

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

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

Objective: By 2025, increase the 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 of 13% from baseline.

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

CHILDREN WITH SPECIAL HEALTHCARE NEEDS (CSHCN)

Coordinated care and assisting parents and caregivers navigate the health care system is the priority for the children with special health care needs domain. It was the primary priority identified by the public input survey and shows room for improvement based on the data of only 46.8% of children with special health care needs reported having a medical home and no recent change in that percentage. Additionally, there are a vast array of programs and agencies that contribute to services in this domain and the priority was ranked high for feasibility and impact as well as program capacity to affect change. This priority aligns with NPM #11- Medical home.

Priority Need: Helping parents/caregivers navigate the healthcare system

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

Objective: By 2025, increase the number of CSHCN who report having a medical home to 39%, an increase of 26% from baseline.

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

SYSTEMS BUILDING

Building workforce capacity to improve the maternal and child health services in the CNMI was chosen as the priority. Participants voiced a need for trained, qualified professionals who can deliver services across domains. This incorporates the survey findings related to priority, family engagement and parent education. The second priority topic chosen by respondents was better and clearer communication about healthy behaviors, health services and supports in the area. Community outreach was chosen as the preferred method for family engagement with 72.7% of respondents choosing that method. Home visiting was chosen as the preferred method of receiving parent education with 57.6% of respondents choosing that method.

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

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

Objectives: By 2025, increase the number of MCH serving professionals who complete training on MCH priorities to 25%.

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

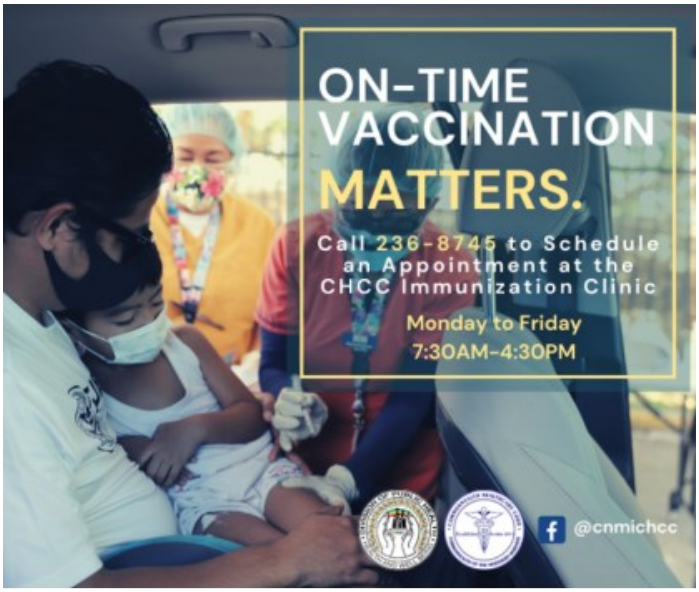
III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

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, Pap tests, 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 MCHB staff, nurses, and partners who impact CNMI Title V priorities.

III.A.3. MCH Success Story

The year 2020 was a significantly challenging time for the entire world. Health departments across the nation were battling the rippling effects of the global COVID-19 pandemic. Vaccination rates among children were impacted with significant decreases in childhood routine vaccinations.

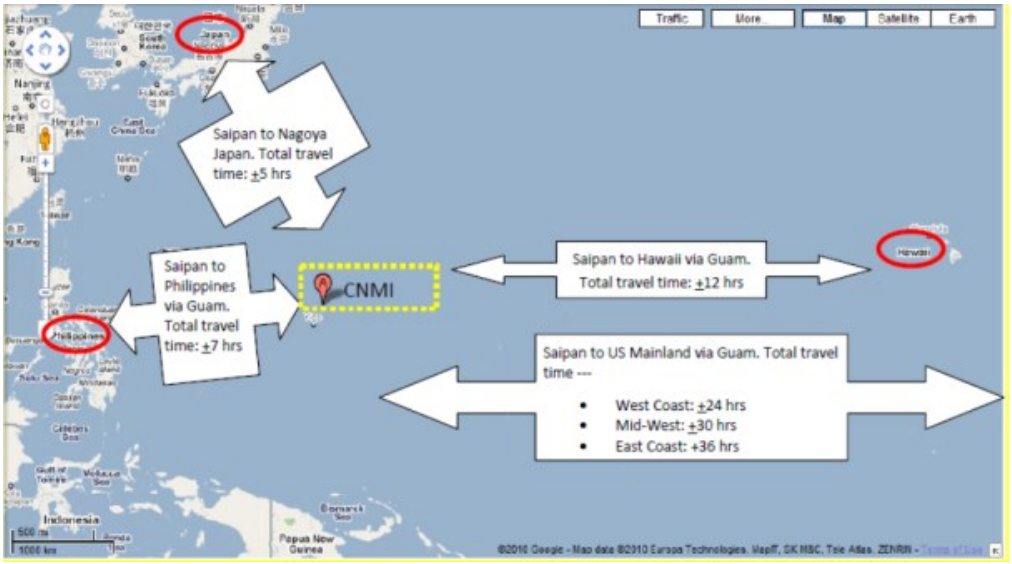


In the CNMI, the CHCC was quick to identify the threat to vaccination coverage that the pandemic had and the risks associated with low vaccination coverage among our CNMI children. The MICAH Administrator, Child Health Coordinator, and MCH Services Coordinator, all positions funded through the MCH Title V Block grant partnered with the Immunization program and the Public School System to develop a strategy for addressing this child health emerging issue. At a time when the CNMI implemented strict restriction of movement efforts, social distancing, masking, and crowd control measures, the team had to identify a strategy that allowed families to feel comfortable, and more importantly, safe in accessing services. The team developed a drive thru vaccination strategy with locations identified in various villages across the island of Saipan. Vaccination data was assessed through the CNMI Immunization registry and families with children who were not up to date or needing catch up vaccinations were contacted by a team of MICAH program staff via telephone and scheduled for drive thru vaccination services.

As a result of these efforts, vaccination coverage rates were not only maintained, but increases in coverage rates were made. In 2020, 71.5% of children ages 19 through 35 months completed their combined 7-vaccine series, a 15.7% increase compared to 2019 (55.8%). Vaccination among teens against HPV increased in 2020 compared to 2019. Among adolescent ages 13 through 17, 95.6% received at least one dose of the HPV vaccine in 2020, an increase compared to 87.5% in 2019.

III.B. Overview of the State

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



In October 2011, Public Law 16-51 dissolved the Department of Public Health and created the Commonwealth Healthcare Corporation (CHCC). CHCC is a quasi-governmental corporation, and while it is a part of the CNMI Government, it is semiautonomous. The CHCC is the operator of the Commonwealth's healthcare system and the primary provider of healthcare and related public health services in the CNMI. This law transferred all the functions and duties of the CNMI Department of Public Health including management of federal health related grants to the Commonwealth Healthcare Corporation, so that the CHCC is the successor agency to the now defunct Department of Public Health. The only hospital in the CNMI is also administered by CHCC. The CHCC is governed by a Board of Trustees and managed by the Chief Executive Officer (CEO) of CHCC. The CEO is the authorized representative for all federal grants, including the CNMI MCH Title V Program. In February of 2020, a reorganization of the CHCC was undertaken. The CHCC operations is now organized under eight (8) sections: Nursing, Medical, Finance, Population Health Services, Hospital, Tinian Health Center, Rota Health Center, and Dialysis Center. The CNMI MCH Title V Program falls with the Population Health Services section and administered under the oversight and direction of the Chief Operations Officer.

Demographics

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

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

Single ethnic groups that accounted for the majority population in the CNMI were identified as Filipino (35 percent), followed by Chamorro (24 percent) and Chinese-except Taiwanese (7 percent). Carolinians make up about 5 percent of the total population. Asians were the largest group representing nearly half of the total population. Native Hawaiian and Other Pacific Islanders made up about 35 percent and Caucasians less than 2 percent. About 13 percent of CNMI's population were of two or more ethnic origins or races.

Table 1 MCH Population

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

Source: U.S. Census Bureau

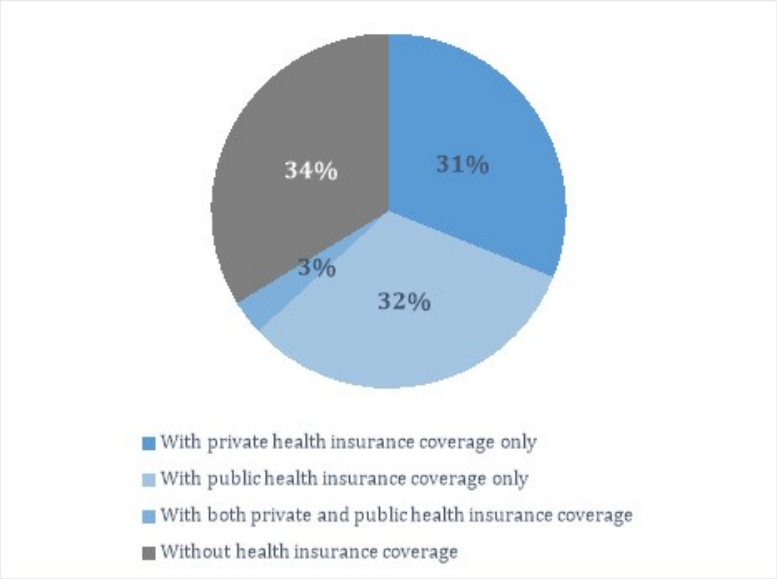
Table 2 CNMI Population by Ethnicity

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

Source: U.S. Census Bureau

CNMI has a large percentage of the population that are uninsured. The 2010 U.S. Census reports the uninsured population in the CNMI at 34 percent, more than double the 15 percent uninsured rate in the United States. A challenge with the uninsured population is the status of the immigrant contract workers who are ineligible for Medicare and Medicaid. In the CNMI, based on 2010 US Census data, residents with Medicaid constitute 32 percent of the population, double the Medicaid rate of the U.S. at 16 percent.

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

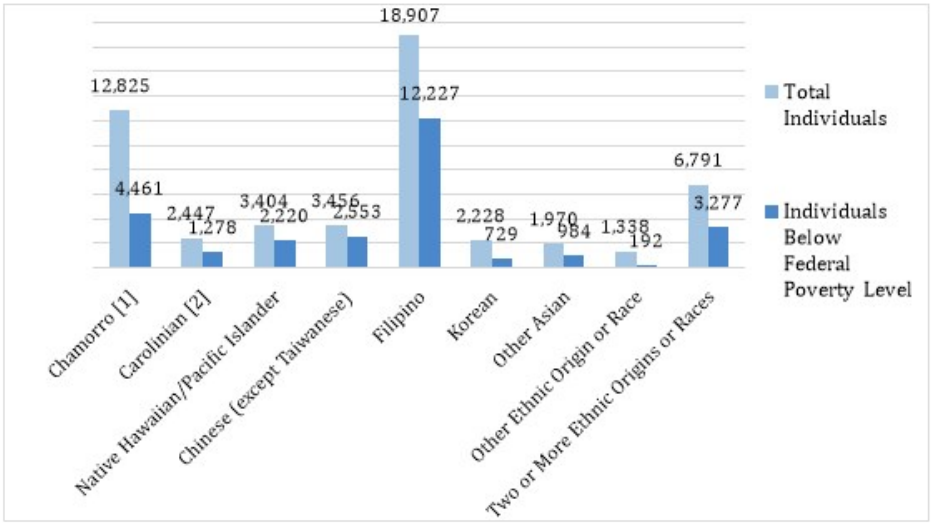


Source: US Census Bureau

Economy

Since 1998, the CNMI's economy has suffered one long continuous, downward spiral. A variety of factors contributed to the current circumstance, including the loss of tourism-related business, the effects of rising fuel costs across all of the CNMI, the closing of the garment manufacturing industry, and the implementation of federal Public Law 110-229, which removed local control over immigration. As a result of this confluence, the CNMI government's revenues have fallen drastically causing the CNMI's annual budget to drop 56 percent - more than $90 million dollars, over the last 12 years. As such, many jobs have been lost resulting in many people without the financial means, education, and experience needing to relocate to the U.S. mainland. According to the 2010 U.S. Census, 4,061 families in the CNMI had an income that was below poverty level with related children under 18 years old. Approximately 52 percent of the total population lived below the federal poverty level. Specifically, 11,693 individuals were living below 50 percent of poverty level, 32,885 individuals below 125 percent of poverty level and 40,368 individuals below 185 percent of poverty level. Approximately 65 percent of the Filipino population, the largest ethnic group, were living below the poverty line.

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



Source: US Census Bureau

Healthcare for the MCH Population

Commonwealth Healthcare Corporation (CHCC)

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

The Commonwealth Legislature cited a desire for the hospital to be an "independent public health care institution that is as financially self-sufficient and independent of the Commonwealth Government as is possible." Although the CHCC now exists as a quasi-independent institution, it remains a public corporation charged with the responsibility of providing essential health care to the people of the CNMI. Yet, since its inception, the CHCC has struggled with the transition from a government agency to a public corporation. And while the CHCC has made progress the past several years in expanding services and increasing access to healthcare, the large uninsured population coupled with minimal funding support from the CNMI government to address indigent care costs continues to challenge the CHCC.

In 2020 CHCC had over 800 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 are offered through the Family Planning program through service sites at the Women's Clinic, Rota Health Center, Tinian Health Center, and during clinic outreach events. Dental health services are also provided at CHCC Dental Clinic. Vaccinations are made available through the Immunization and Vaccines for Children (VFC) program, which oversees enrollment of VFC sites throughout the CNMI. VFC sites, which include private

clinic providers, provide vaccinations to children and adolescents.

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

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

Early intervention services for infants and toddlers with special healthcare needs ages zero to three years are provided through a collaborative effort of the CNMI Public School System and the Commonwealth Healthcare Corporation. Funding for services for early intervention services is provided through Part C of the Individuals with Disabilities Act. The CNMI Public School Systems is designated by the CNMI Governor as the Lead Agency for carrying out the general administration, supervision, and monitoring of the early intervention program and activities in the CNMI. Services for children with special healthcare needs age three to five years are provided through the CNMI Public School System's Early Childhood Program and for those ages five through 21 years through the Part B, Special Education Program. The following services are available for children with special healthcare needs in the CNMI: audiology services, occupational therapy, physical therapy, service coordination, sign language services, speech-language pathology services, vision services, psychological services, and counseling. According to the CNMI Public School System, during the 2019-2020 school year, there were 74 infants and toddlers enrolled in Early Intervention Services program, 66 enrolled in the Early Childhood Special Education program, and 927 enrolled in the Special Education program[i].

As a joint effort formalized through an Interagency Agreement, the CHCC MCH Program provides service coordination for infants and toddlers who are enrolled in Early Intervention Services. The CNMI Title V MCH Program facilitates and/or supports programs for the early identification of children from birth through five and supports referrals of children with special healthcare needs to Early Intervention services.

Rota Health Center

The Rota Health Center is the only medical facility on the island of Rota and services the entire population of about 2,500. At present the Rota Health Center has one physician, two full time mid-level providers, five nurses, two laboratory technicians, and 2 pharmacy technicians. The auxiliary staff includes two x-ray technicians, two lab technicians and twenty-three administrative support staff. 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 about 3,200. At present, the Tinian Health Center has three mid-level providers, five registered nurses, five licensed practical nurses, one certified nursing assistant, one phlebotomist, one radiology technician, and one dental assistant. The Tinian Health Center operates an emergency, outpatient clinic, pharmacy, laboratory, and radiology units. Public Health services such as Family Planning Program, Breast and Cervical Cancer Screening, and HIV/STD Screening are available at the Tinian Health Center.

Federally Qualified Health Center (FQHC)

Kagman Community Health Center (KCHC)

The establishment of the Kagman Community Health Center, a federally qualified health center (FQHC), in 2012 located in one of the remote villages in the southeast part of Saipan has improved access to healthcare services for the MCH population. The KCHC provides outpatient services such as: general primary care, basic diagnostic laboratory, screenings, family planning, well-child, gynecological care, obstetric care, preventive dental, case management, health education and outreach.

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

Challenges that Impact Access to Healthcare

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

Uninsured Population

CNMI has a large percentage of the population that is uninsured. The 2010 U.S. Census, administered prior to the implementation of the Patient Protection and Affordable Care Act (PPACA), reports the CNMI uninsured population at 34 percent, more than double the 15 percent of uninsured in the US. In 2013, CNMI Public Law 17-92 was passed, which released employers from the responsibility for providing health insurance coverage to non-U.S. qualified workers (legally-present foreign workers). The rate of the uninsured has not been reassessed since this law was passed but has likely increased after this policy change.

Inter-Island Medical Referral Services

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

Off-island Referrals

Treatment services, including access to diagnostic services, not readily available in the CNMI are handled through the Medical Referral Program. Patients are referred to healthcare facilities in Guam, Philippines, Korea, Taiwan, Hawaii, or the US mainland. In 2004 the number of off-island medical referrals was 437 patients and since that time the number of referrals has increased steadily to 565 patients in 2007, 924 patient referrals in 2009, and 1,117 patients in 2010. There was a 155% increase in the number of patients referred for off-island care between 2004 and 2010. In an interview with the CNMI Medical Referral Office Director, Ronald Sablan, it was noted that the rise in medical referral patients is largely attributed to a lack of medical maintenance among patients. Patients are increasingly forgoing preventive care and seeking medical attention when health conditions or diseases are at their worst stages and requiring care not readily available on island[ii]. An economic crisis that began in the year 2000 impacted both the CNMI population's ability to be able to access healthcare, more importantly, preventive healthcare and government spending, including spending on healthcare. In the year 2000, the CNMI's garment manufacturing industry began to slowly close its doors until it eventually completely phased out in 2006. In addition to this, tourism, the CNMI's second largest industry experienced a major decline. Together, the tourism and garment manufacturing industries accounted directly and indirectly for about 80 percent of all employment in the CNMI in 1995 and made up a large part of the government revenues[iii]. The economic condition of the CNMI during the early 2000s is one in which many individuals were out of employment and the government had little to no means of extending support or relief to community members in response to the economic crisis. Studies have shown that unemployment rates are linked to

preventive healthcare utilization, with increases in unemployment corresponding to decreases in individuals completing preventive health services such as pap smears, mammograms, and annual checkups[iv].

Data from the CNMI Medical Referral Program for 2020 indicates that there were a total of 941 referrals for medical care outside of the Northern Mariana Islands, down from 1,788 patient referrals in 2019 and 1,815 in 2018.

A large majority (70%) of the referrals were sent to the neighboring island of Guam, with radiology and MRI studies being the major reasons for referral. Overall, the major health categories for referrals include cardiology, MRI studies, neurosurgery, and radiology.

Health Coverage for MCH Population

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

Medicaid

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

The framework for Medicaid financing in the CNMI resembles that of the fifty states: the cost of the program (up to a point) is shared between the federal government and the Territory and the federal government pays a fixed percentage of the CNMI Medicaid costs. For the CNMI, that fixed percentage is 55 percent. However, unlike the 50 states, the federal government pays a fixed percentage of the CNMI Medicaid costs within a fixed amount of federal funding. If CNMI Medicaid expenditures exceed the territory's federal Medicaid cap, which was $6.3 in FY 2017, the CNMI becomes responsible for 100 percent of Medicaid costs going forward. Moreover, the CNMI receives a relatively low fixed percentage, which is known as the Federal Assistance Percentage, or FMAP. The FMAP rate for the CNMI is and historically has been lower than most of the 50 states. The formula by which the FMAP is calculated for the 50 states is based on the average per capita income for each state's relative to the national average. Thus, the poorer the state, the higher the federal share, or FMAP, is for the jurisdiction in a given year. However, due to the statutory restrictions on Medicaid financing for the Northern Mariana Islands, the FMAP provided the CNMI is not based on per capital income of residents, thus the territories' FMAP does not reflect the financial need of the CNMI in the same ways that the 50 states' financial needs if represented. Pre-PPACA, the CNMI and other territories were statutorily capped at 50 percent. In 2011, the rate increased to 55 percent FMAP and jumped again to 57.20 percent until December of 2015, and has dropped again to 55 percent FMAP. In contrast, some states receive over 80 percent FMAP.

According to the Medicaid and CHIP payment and Access Commission (MACPAC), in fiscal years 2011 thru 2017, the federal spending for Medicaid in the Northern Mariana Islands exceeded the annual funding ceiling. This spending reflects the use of the additional funds available under the PPACA. The CNMI Medicaid Office has exhausted the additional funds made available by the PPACA in April 2019. As a result of this, all healthcare for Medicaid population has been directed towards the CHCC, away from private clinic providers. The CHCC Women's and Children's clinic has experienced an influx

of patients due to this policy resulting in clinic appointment availability extending from one and half to two months out.
In general, once the CNMI exhausts the federal Medicaid and CHIP allotments, the territory must fund the program with local funds. However, recent supplemental federal funds have been made to the CNMI, beginning with the FY2020 appropriations package, signed into law in December 2019 and then the Families First Coronavirus Response Act, effective March 2020.

These supplemental funds raised the CNMI's FY2020 Medicaid funding allotments rom $6.9 million to $63.1 million and its FY 2021 allotment from approximately $7.1 million to $62.3 million. Congress has not made any additional funding available to the CNMI after September 30, 2021, which means that beginning October 01, 2021, and future years, federal funds for the CNMI's Medicaid program will revert back to the capped amount set in statute (approximately $7.2 million for FY 2022).

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

Policies and Regulations that impact MCH Populations

Public Law 01-33 School Immunization Act of 1979.

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

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

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

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

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

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

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

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

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

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

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

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

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Annual Needs Assessment Update

Process

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

Active participation in community events and partner meetings allows the program to interact with stakeholders and gather valuable qualitative information that is used to further guide program activities.

In addition, membership on local groups and committees such as the Disability Network Providers (DNP), Early Intervention Services Program's Interagency Coordinating Council, and the Head Start Advisory Council (HSAC) provides MCH the opportunity to network with agency partners for obtaining updates on annual plans, objectives, needs, and any emerging issues occurring through partner programs.

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

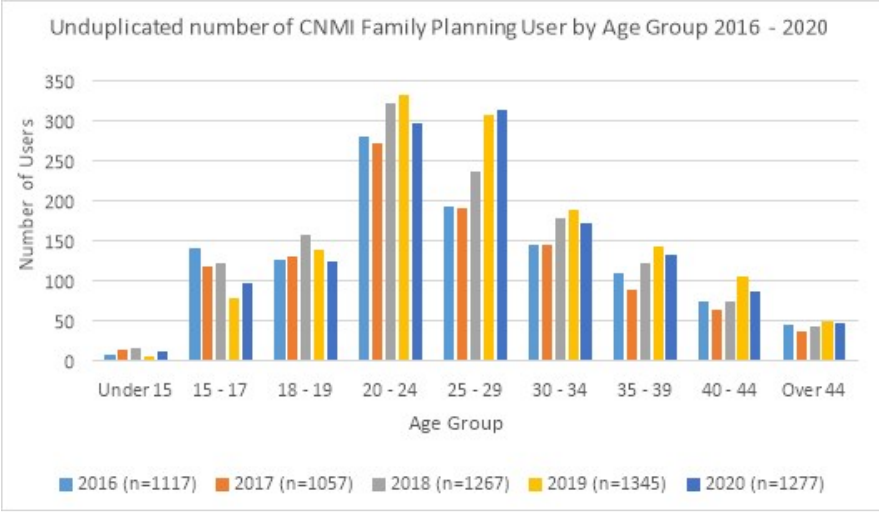
The MCH Jurisdictional survey was implemented in 2020 in the CNMI, providing additional data source for gathering valuable MCH data to inform annual needs assessment activities as well as serving as a data source for National Outcome Measures (NOMs) and National Performance Measures (NPMs) that the CNMI did not have sources for.

In May 2021, the CHCC was awarded funding through the Centers for Disease Control and Prevention (CDC) to implement the Pregnancy Risk Assessment Monitoring System (PRAMS). The PRAMS collects jurisdiction-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. PRAMS surveillance currently covers about 81% of all U.S. births. The CNMI MCH will utilize the PRAMS data to investigate emerging issues and to plan and review programs and policies aimed at reducing health problems among mothers and babies. Data collection for sampled birth records will begin in the spring of 2022.

MCH Population Needs

Maternal/Women's Health

The CNMI Family Planning program serves men and women of reproductive age and provides the following services at low to no cost, regardless of an individual's ability to pay: pregnancy testing, STD/HIV screening and treatment, basic infertility services, contraceptive counseling and access to a wide range of contraceptives, breast and cervical cancer screening, referrals to community programs and other related health services (i.e WIC, prenatal care, etc.).

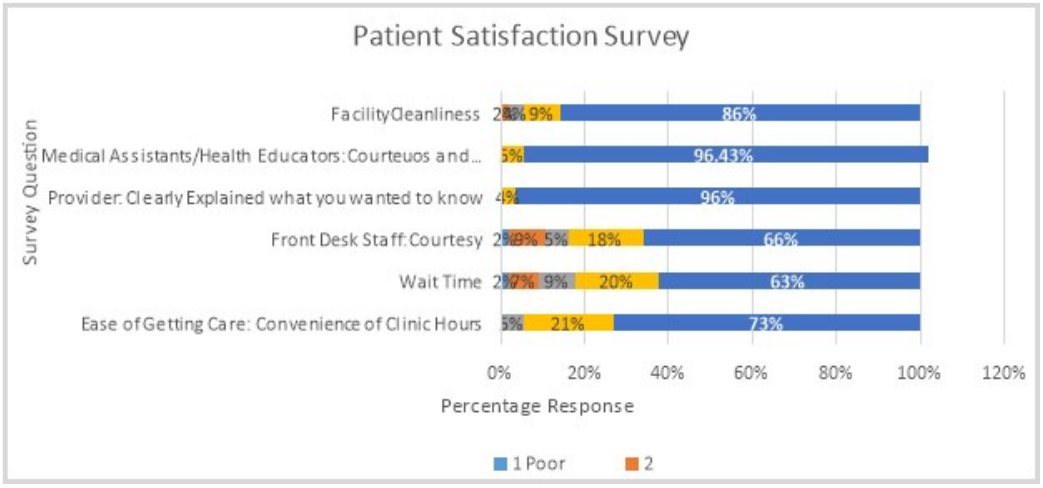


Source: CNMI Family Planning Annual Report (FPAR)

Annually, the Family Planning program serves an average of 1,200 clients, a large majority women of reproductive age with a large proportion among the 20 to 24 and 25 to 29-year age groups. While there was an overall decrease in the number of unduplicated clients seen in 2020, the program saw increases among the 15 to 17 and 25 to 29-year-old age groups compared to the year prior.

In 2020, a patient satisfaction survey among Family Planning program clients seen at the main service site, CHCC Women's Clinic, was conducted. A total of 100 surveys were completed. The survey was intended to gather information to identify areas of improvement to be prioritized that would improve overall satisfaction of program services as a means for improving service utilization and improve health outcomes among individuals of reproductive age.

Of the patients surveyed, a large majority rated the medical assistant/health educators and the providers as "Excellent" (96%). The Front Desk Staff, Wait Time, and Convenience of Clinic Hours were identified as areas to focus improvement on, with ratings of "Excellent" at 66%, 63%, and 73%, respectively.



Source: 2020 Family Planning Client Satisfaction Survey

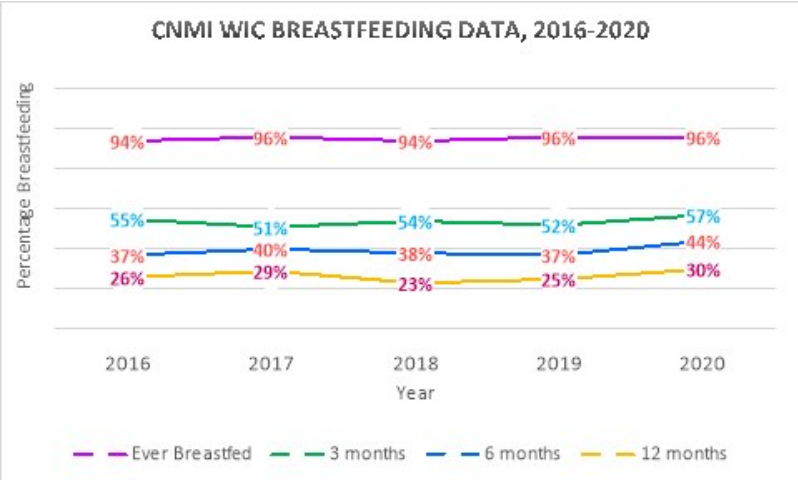
Preventive visit rates among women of reproductive age in the CNMI has remained stable for the past few years. In 2020, 41.9% accessed preventive healthcare, based on electronic health record review of women accessing care at the

Commonwealth Healthcare Corporation. This percentage is a slight increase compared to 2019 year which identified 41.3% of women accessing preventive healthcare and a larger increase compared to the 2016 data of 33.9%.
While there have been increases the past 5 years in preventive healthcare utilization among women of reproductive age, the CNMI's rates still lags behind the US national average. In 2018, for example, 73.6% of women of reproductive age accessed preventive healthcare in the United States.
In the CNMI, gynecological cancers are the most diagnosed forms of cancer. Two (2) screening tests, pap smear and human papillomavirus (HPV) screening, are known to help prevent cervical cancers, a form of gynecological cancer, or detect them early so that they are treatable. According to the 2016 CNMI NCDB Hybrid Survey, only one-third of CNMI adults report having an annual wellness exam and fewer than half (43.2%) of women ages 21- 65 report having a pap test done within the past 2 years. These data clearly illustrate key findings related to preventive healthcare access of the CNMI population and more importantly highlights that there are challenges or barriers women experience in accessing available preventive care, such as pap exams.
Data recently gathered from the CHCC Electronic Health Records (EHR) system from years 2014-2020 showed that 5,623 women between the ages of 21 – 65 years had a cervical cancer screening recorded in the EHR, of which 71.1% (3,998) were up to date of the screening guidelines as of December 31, 2020 and 28.9% (1,625) were out of date. Of the 28.9% out of date, 48.2% (784) women had a visit in 2020 after they were out of date and 52.6% of these 784 women had 6 or more visits (total of 2,260 encounters), representing a missed opportunity to reduce delays in screening, diagnosis, and treatment.
The data shows potential opportunities for strengthening CHCC health system policies and/or protocols to be able to identify and provide pap screenings for women who are already accessing the CHCC health system.

Perinatal/Infant Health

Breastfeeding

While breastfeeding initiation rates in the CNMI of 95.8 percent is higher than US national rate of 83.2 percent[i] , its 6 months breastfeeding rate (44%) trails behind the US average of 57.6 percent. Review of 2020 data on CNMI infants breastfed highlights increases in breastfeeding rates among CNMI infants compared to the year prior. The most recent data shows that 57 percent of infants are breastfed at 3 months, 44 percent at 6 months of age, and 30 percent at 12 months. High breastfeeding initiation rates indicates that a vast majority of mothers in the CNMI want to breastfeed and start out doing so. However, despite the recommendations for exclusive breastfeeding through 6 months, less than 1 percent of CNMI infants are breastfed exclusively at 6 months of age.



Data Source: CNMI WIC Program

Many factors contribute to success in continued breastfeeding and support to breastfeeding moms is critical. Having to return to work is one factor and women typically return to work within one month after childbirth. CNMI government

employees are allowed just 15 days of maternity leave; maternity leave policies for private businesses vary. Little is known about the types and level of breastfeeding support provided by local employers.

Donor Breastmilk

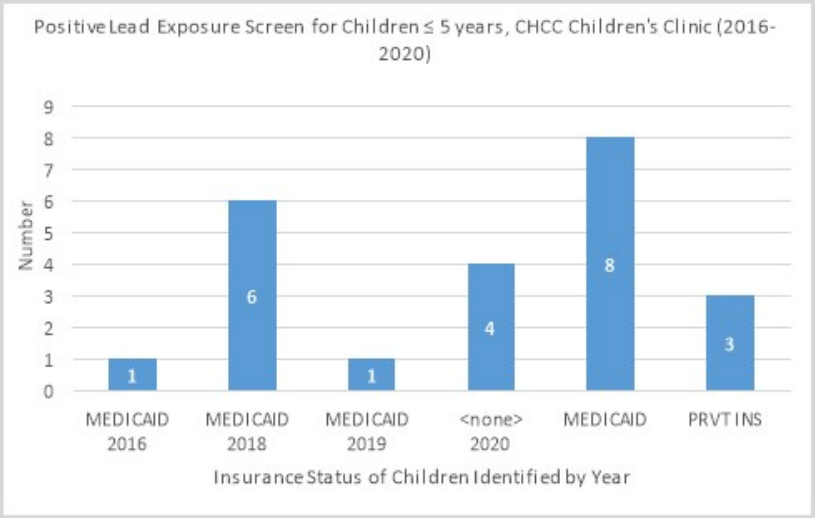
Donor breastmilk for infants admitted to NICU in the CNMI was identified as a need by CHCC Pediatrics Department for prevention of complications seen among infants in the NICU, such as necrotizing enterocolitis. The availability of donor breastmilk will provide babies who would otherwise not receive human milk to grow healthier and reduce the risk for morbidity and mortality into their future development.

Through the efforts of the CHCC Pediatrics team, and led by Dr. Julio Pena, a milk bank was identified in San Diego who was willing to enter into an agreement to ship donor breastmilk to the CNMI. A CHCC policy on Donor Breastmilk was identified and Title V funds will be used to support the procurement and transport of this critical resource.

Child Health

Lead Exposure

The CHCC Children's Clinic saw a significant increase in the number of children ages 5 years and below identified for exposure to lead.



Source: CHCC RPMS, HER

Data from the CHCC Electronic Health Record system for the past 5 years indicates there were more kids identified in 2020 compared to the previous 4 years combined. According to the CHCC Pediatrics department, the increased reporting of lead exposures in children are likely due to multiple factors including but not limited to increased accessibility to testing with point of care screening available in the children's clinic; increased consistency of lead testing at the 12, 24, and 3 to 5 year well child visits; and possibly more time at home due to quarantine may have resulted in more children having contact with lead based substances.

Obesity

In 2020, the MCH Program worked with an MPH student intern from Emory University, Cindy Rosales, to conduct focus groups and key informant interviews among stakeholders in the CNMI. The project involved conducting a gap analysis by gathering qualitative data to inform strategic action planning for addressing childhood obesity rates in the Northern Mariana Islands. Interviews, listening sessions, and focus groups with an array of public health partners and community members were conducted to learn about opportunities and barriers within the CNMI Commonwealth Healthcare Corporation's direct sphere of influence for addressing childhood obesity in the territory. The results from

the activities were synthesized and will be used to communicate findings and develop recommendation for action to key decision makers and other stakeholders. This work will assist the CHCC in focusing strategic planning efforts (both population based and clinical interventions) and inform the development of the MCH Title V- 5 Year State Action Plan for addressing childhood obesity.
The project resulted in the development of a code book, interview recordings, literature review summary report, research question and interview guide, over 100 pages on interview summaries with coded segments, and a summary of findings.
Interview participants included administrators or directors of the following programs/agencies:

Non-Communicable Disease Bureau (CHCC)
Northern Marianas College- Expanded Food Nutrition and Education Program (PSS)
Diabetes Prevention & Control Program (CHCC)
Nutrition Assistance Program (NAP) (DCCA)
Office of Curriculum & Instruction (Public School System)
Child Nutrition Program (PSS)
Pediatrician- CHCC
Pediatrician- CHCC
Registered Dietitian- CHCC
Registered Dietitian- CHCC
Special Assistant for Policy- CHCC
WIC- CHCC
Child Care Development Block Grant Program (DCCA)
Early Head Start/Head Start (PSS)

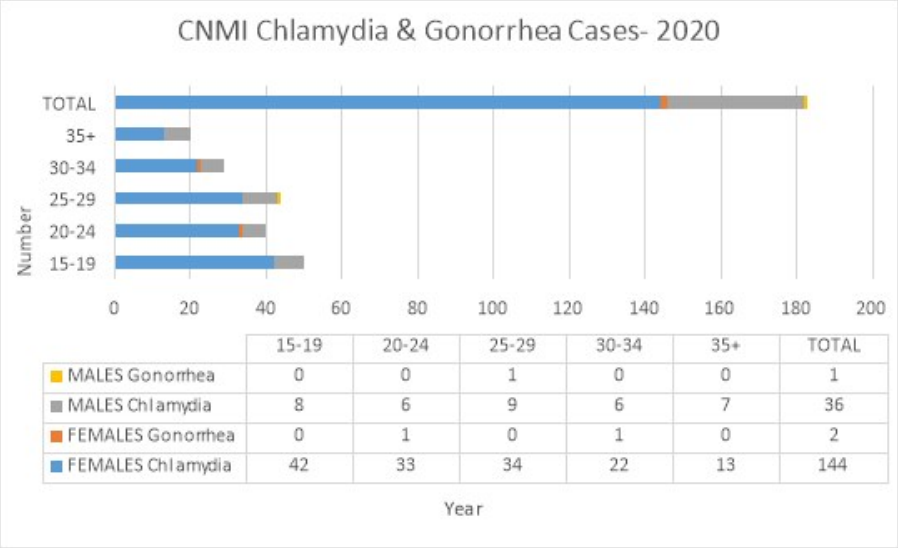
Findings from the project highlighted challenges and opportunities in the areas of nutrition and physical activity. Challenges for nutrition identified include: the lack of variety in fresh produce selection that impacts CNMI residents from choosing healthier options; the time taken to prepare healthy food choices; perception of the high cost of healthier food; access to information that can help or hurt families in making decisions about food and availability of the information. Nutrition facilitators included: CNMI residents and families are farming/gardening for fresh healthy produce making themselves self-sustainable; outreach campaigns or increasing information about healthy choices. Opportunities for improvements and future strategies were also highlighted by the project.

Adolescent Health

Sexually Transmitted Infections

During 2020, there were 180 reported cases of chlamydia and 3 reported cases of gonorrhea. A majority (80%) of the cases were reported among women with more than half (52%) among women between the ages of 15 through 24 years. While usually asymptomatic, if left untreated, chlamydia infection in women can lead to pelvic inflammatory disease, a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. Chlamydia is easily detected and, if identified, treatable with antibiotics. Screening is critical as it is estimated that about 75% of infections among female and 95% among male is asymptomatic[ii].

CNMI Chlamydia & Gonorrhea Cases- 2020



	15-19	20-24	25-29	30-34	35+	TOTAL
MALES Gonorrhea	0	0	1	0	0	1
MALES Chlamydia	8	6	9	6	7	36
FEMALES Gonorrhea	0	1	0	1	0	2
FEMALES Chlamydia	42	33	34	22	13	144

Data Source: CHCC STD/HIV Prevention & Treatment Program

Title V Program Capacity

Organizational Structure & Leadership

The Title V Block Grant is administered within the Population Health Programs (PHP) section under the Commonwealth Healthcare Corporation (CHCC). The CHCC has a Governor-appointed Board of Directors and in that way is part of the central government of the CNMI.

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, including management of federal health related grants. The Chief Executive Officer of CHCC is the authorized representative for the MCH Program and the Administrator for the Maternal, Infant, Child and Adolescent Health unit is the Project Director for the award. The Chief Operations Officer (COO) also provides oversight to the programs under MICAH, including the MCH Title V program.

In 2014, CHCC programs serving women and children were combined to form the Maternal and Child Health Bureau (MCHB). Subsequently in the spring of 2021, the MCHB was restructured to include the Immunization and WIC programs and renamed into the Maternal, Infant, Child and Adolescent Health (MICAH) Programs. The Title V Block Grant is administered through the CHCC MICAH Programs. The MCH Program is one of the seven programs under the MICAH, along with Family Planning, Universal Newborn Hearing Screening/Early Hearing Detection and Intervention Programs, H.O.M.E. Visiting, WIC, Immunization and Vaccines for Children (VFC), Family to Family Health Information Center, and State System Development Initiative. The Administrator for the MICAH Programs also serves as the MCH Program Coordinator.

All MCH services are provided at the Tinian and Rota Health Centers either directly or through Resident Directors or rotating physicians.

Agency Capacity

The CHCC through its health system structure, provides primary and preventive health services to the CNMI. Services include medical, dental, mental health, substance abuse counseling, nutrition/dietary services, oncology, preventive screening and testing, among others. Collaboration with other Public Health programs and community

partners make it possible to bring health services out into the community via outreach. This work is supplemented by enabling services including outreach, case management, educational materials, and transportation for MCH target populations. The MCH Program has strong collaborative relationships with key physician providers for the MCH populations. The Chief Obstetrician/Gynecologist, Chief Pediatrician, Family Planning Medical Director, Chief Dentist, and Medical Director of Public Health all guide and support the program.

Maternal Child Health Workforce Development and Capacity

Medical Director of Public Health: **Dr. Lily Muldoon** is an emergency medicine physician at the Commonwealth Healthcare Corporation of Saipan and was appointed to the position of Medical Director of Public Health of the CNMI in June 2021. Dr. Muldoon received a Medical Degree from the University of California San Francisco and a Masters of Public Health from the Harvard School of Public Health. She is a Fulbright Scholar and has extensive past experience in health system strengthening and improving maternal and child health on remote islands of East Africa.

Family Planning Medical Director/OB/GYN: **Dr. Maria Hy,** graduated from University of Kentucky College of Medicine 2010 and completed her obstetrics and gynecology residency at Christiana Care Hospital in 2014. She is an OB/GYN for the CHCC and also serves as Medical Director for the Title X Family Planning program.

Pediatrics Department Chairwoman- Dr. Sadie LaPonsie is board-certified in general pediatrics and pediatric hospital medicine. She completed medical school at Michigan State University, residency at Northwestern University / Lurie Children's, then worked for five years as a pediatric hospitalist in the Chicago area until relocating to the CNMI in summer 2020. She has held numerous teaching and leadership positions through Northwestern University, the University of Chicago, and the American Academy of Pediatrics. Her clinical interests and expertise include high-value inpatient care, family-centered care, quality improvement, advocacy, and health equity.

Pediatric Nurse Practitioner and IBCLC- **Heather Brooke** is a Pediatric Nurse Practitioner at the CHCC Children’s Clinic and the only International Board-Certified Lactation consultant in the CNMI. She graduated from University of Minnesota in 2015 with a Doctorate Nursing Practice. She developed an interest in breastfeeding medicine when she felt ill prepared as a primary care provider to help mother-baby dyads with breastfeeding difficulties and realized that the locally poor breastfeeding rates, which started out high and quickly tapered off, were more likely a product of lack of support than disinterest. The interest turned into a passion and now helping moms and babies have successful breastfeeding journeys is the best part of her job.

MICAH Programs Administrator/MCH Title V Project Director: Heather Santos Pangelinan, assumed the role as MCH Program Coordinator and Administrator in August of 2016. As Administrator, she works closely with the several Project Coordinators to manage the programs under MICAH. Mrs. Pangelinan has a MS in Counseling from Grand Canyon University and started her career in Public Health as a Data Specialist for the MIECHV Home Visiting program. She later served as the CNMI Early Childhood Comprehensive Systems program coordinator. Mrs. Pangelinan has been with the CHCC since 2014.

SSDI Project Coordinator: Richard R. Sablan graduated from California State University San Bernardino with a BS in Health Science, with emphasis in Public Health Education. Related coursework completed included:

Statistics for the Health Sciences, Research Methodology in Health Science and Health Program Planning, Implementation and Evaluation. The SSDI Project Coordinator is responsible for managing and improving MCH data collection, analysis, and reporting. The incumbent in this position works closely with the Public Health Medical Director/MCH Epidemiologist.

MCH Services Coordinator: Tony Yarobwemal holds a Master's of Science degree in Education. Prior to his role as MCH Services Coordinator, Mr. Yarobwemal was the Health, Nutrition and Mental Health Manager for the CNMI PSS Head Start Program. As MCH Services Coordinator, Mr. Yarobwemal is responsible to managing referrals to the MCHB, including conducting risk and other needed assessments to be able to assist women, children, and families access health services.

Child Health Coordinator/CSHCN Director: Danielle Youn Jung Su holds a Master's of Science in Education in Rehabilitation Counseling and a Bachelor of Art's degree in English Language Arts, both from Hunter College of City University of New York. Ms. Su is a Certified Rehabilitation Counselor (CRC). As the Child Health Coordinator, her work focuses on development, coordination, implementation and evaluation of children, including children and youth with special health care needs programs and related activities.

Partnerships, Collaboration, and Coordination

The CNMI Public School System continues to be a major partner for strategies and activities targeting children ages zero through 17 years. The PSS Early Intervention Services Program and the Early Head Start program serve children from birth through 3 years. PSS serves children ages 3 through 5 years in Head Start programs and children ages 6 through 17 years are enrolled in PSS K through 12th grade programs. The CHCC has formal MOUs with the PSS to collaborate on programs serving children enrolled throughout the system. CHCC population health programs collaborate with PSS to offer training/capacity building, school based screening services (such as STD/HIV and diabetes or hypertension), as well as other sexual and reproductive health services, such as counseling and access to contraceptives to prevent teen pregnancies and STD transmission. Other initiatives that CHCC has partnered with PSS are: Developmental Screenings, Bullying Prevention, Teen Pregnancy Reduction, Improving Immunization rates, Nutrition, and Physical Activity.

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

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

The Disability Network Partners (DNP) consists of programs that provide services to individuals with special healthcare needs and their families. The Northern Marianas College's University Centers of Excellence in Developmental Disabilities, CNMI Office of Vocational Rehabilitation, and Developmental Disabilities Council are the agencies that form that core group of the DNP. Other partners involved in the DNP include the Northern

Marianas Protection and Advocacy Systems Inc. (NMPASI), Public School System Special Education Program (SPED), Center for Living Independently (CLI), and the MCH Bureau. The DNP meet on a quarterly basis and work on projects such as the CNMI Disability Resource Directory, and the Annual Transition Conferences.

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

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

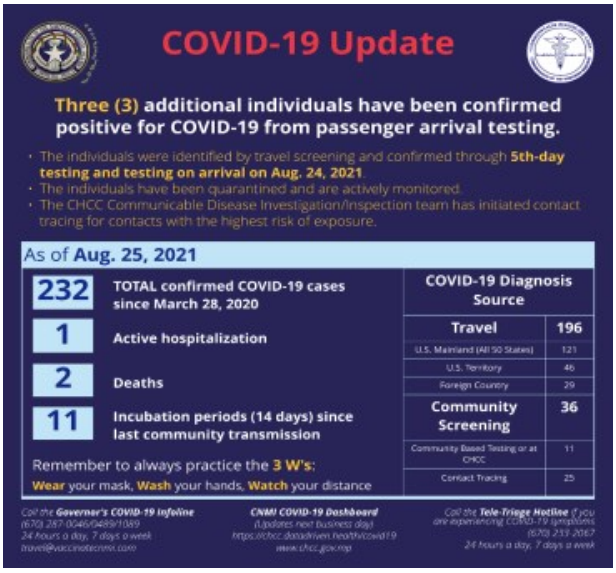
The program coordinates with the Health & Vital Statistics Office, CHCC HIT Dept., and CHCC Medical Records Department on initiatives involving access and improving quality of population-based data.

Emerging Public Health Issues

COVID-19

Reports of a novel coronavirus had made its way to the CNMI and on January 29, 2020, the CNMI governor issued an executive order declaring a state of significant emergency regarding the novel coronavirus that ordered the Commonwealth Healthcare Corporation (CHCC) to implement quarantine and preventive containment measures. On March 16, 2020, Executive Order 2020-04, as amended, was issued declaring a State of Public Health Emergency and a continued Declaration of a State of Significant Emergency establishing response, quarantine, and preventive containment measures concerning COVID-19. This resulted in the CHCC establishing an agency emergency operations center and redirected all health department personnel to aid in the response to the novel coronavirus. In addition, and as result of the first cases of COVID-19 in the CNMI identified on March 28, 2020, subsequent executive orders were issued which implemented stay at home orders, curfews, and other restrictions to ensure the containment of COVID-19. Because of the fragile state of our territory health system, it was critical that preventive measures, including quarantine and other containment strategies, were implemented expeditiously to reduce the risk of potential major adverse impact. These measures resulted in modifications to healthcare services and for a temporary period required that preventive/primary care visits be offered via telehealth; program outreach activities were suspended for the remainder of FY2020.

The CHCC, as the Territorial Health Department, initiated its agency emergency operations center and staff throughout the organization were activated to respond to the public health emergency. Boarder entry screening was implemented with all incoming travelers into the CNMI screened for COVID-19 and on March 23, 2020, the CNMI opened its first quarantine site where incoming travelers were required to quarantine for 14 days. A few weeks later, on April 01, 2020, a second quarantine facility was opened.



As of August 26, 2021, there are 232 total confirmed COVID-19 cases in the CNMI since March 28, 2020 and 2 deaths. A large majority of the confirmed cases were identified through travel testing with a majority of cases originated from the US mainland.

Impact to MCH Program Services

All MICAH Programs staff took on emergency response roles in various sections including planning, communications, contact tracing, entry screening, and quarantine site operations immediately as the CNMI public health emergency was declared in March.

MCH program services were temporarily suspended beginning in March 2020 as health department personnel took part in response efforts. In May 2020, as quarantine efforts garnered good results in containing COVID-19 in the CNMI, staff returned to MICAH programs to begin the process of assessing priorities and activities that could be reasonably conducted during the pandemic. Home visiting services transitioned to telehealth visits, group prenatal care sessions were suspended, Family Planning implemented a drive thru contraceptive pick up service, parent training events offered virtually via zoom, WIC services offered through telehealth, and vaccination offered through drive thru in addition to pediatrics clinics. All educational and clinical outreach events were cancelled for the duration of 2020.

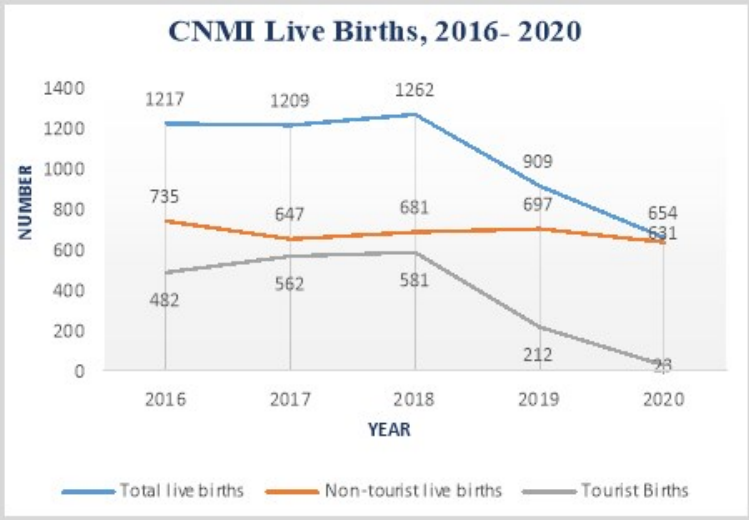
Impact to Preventive Healthcare and Hospital Services

A couple of weeks prior to the confirmation of the first positive COVID-19 cases in the CNMI, the CHCC began implementation of telehealth services at its outpatient clinics to prevent total disruption in preventive health services. Hospital policies were amended to restrict patient visitors and restrictions on birthing companions at the labor and delivery units were put in place. Additionally, the CHCC outpatient pharmacy began offering drive thru services and the dental clinic temporarily closed to non-emergency visits.

Impact to Births

Perhaps the biggest impact the COVID-19 had was to the CNMI's live birth rate. While births to tourists had already been declining in 2019 due to changes to the CNMI's tourist waiver policies, the most significant decrease occurred in 2020 with a drop of approximately 89% in tourist births compared to the year prior. Births to non-tourist women were trending upwards after 2017 and then declined in 2020 during the pandemic.

Live births in the CNMI, 2016 - 2020



Data Source: CNMI HVSO

There were 654 total live births in the CNMI in 2020, a 46% decline compared to 2016. Of the 654 total live births, 631 were to non-tourist mothers and 23 were to tourist mothers.

Impact to Medicaid

As a result of the COVID-19 pandemic, and federal support made through US legislation, several state plan amendments were made that expanded coverage to many individuals in the CNMI including:

- May 20, 2020: State Plan Amendment to 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, to extend coverage to 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.

By the end of FY2020, approximately 70% of the CNMI population was enrolled in Medicaid.

[i] Centers for Disease Control and Prevention. (2018). Breastfeeding Report Card.
[ii] Meyers, D.S., H. Halvorson, S. Luckhaupt. 2007. “Screening for Chlamydial Infection: An Evidence Update for the U.S. Preventive Services Task Force.” *Ann Intern Med* 147(2):135–42

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

METHODOLOGY

CNMI chose a conceptual framework for the needs assessment process that uses a primary prevention and early intervention-based approach with the goal of optimizing health and well-being among the MCH population, taking into account the many factors that contribute to health outcomes. The CNMI developed this view collaboratively by discussing the overall framework with the MCH Needs Assessment Steering Committee and by subsequently building consensus for this approach with the MCH Advisory Group (both described below in Leadership and Stakeholders).

For purposes of assessment and strategic planning, the MCH population was defined as per the domains of women/maternal, perinatal/infant, children, adolescents, children with special health care needs, and cross-cutting/systems building. The overall goal of the process focused on identifying a set of definite priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based interventions grounded in sound public health theory or research and consistent with the mission and scope of CNMI's MCH program. A clear MCH public health role needed to exist for an issue to be considered as a potential priority. The process focused on meaningfully involving multiple state and community stakeholders and partners to enhance collaboration, while looking for opportunities to coordinate and integrate MCH efforts externally and internally across the MCH continuum.

The needs assessment served as a vital planning process for determining where best to focus CNMI's MCH efforts to implement programs, policies and systems building efforts that will measurably demonstrate impact within five years. CNMI also employed a strategic planning process to examine how these new priority areas can be incorporated into the existing MCH scope of work. The mixed methods design provided opportunities for a range of input and ensured diverse representation across the CNMI: from youth to adults; parents to providers; and staff to consumers.

Leadership and Stakeholders

CNMI's needs assessment process was guided by the MCH Needs Assessment Steering Committee. The Steering Committee, which represents the leadership of the MCH program, is responsible for overseeing the development of the needs assessment. With leadership from the Maternal Child Health Bureau Administrator, also MCH Program Coordinator, this group established the overall strategic direction and methodology for the needs assessment while providing the ongoing project management and oversight for the process.

Criteria used for selecting stakeholders included their area of expertise and workplace setting (e.g., geographic perspective), training and experience, knowledge of public health, and their ability to conceptualize at the strategic level, while not solely advocating for a single issue. Members solicited feedback from their own constituencies/ stakeholders in between meetings which greatly expanded the reach of this effort.

Data Assessment

CNMI assessed the needs of the MCH population using Title V indicators, performance measures and other quantitative and qualitative data. The consulting advisor reviewed major morbidity, mortality, health problems, gaps and disparities for the MCH population in order to identify specific needs by MCH population domain based on analysis of data trends. The advisor spent time determining data needs and gaps, and reviewing data findings.

Specially, the CNMI:

- Reviewed the 2015 Needs Assessment and interim needs assessment findings and noted trends since the last assessment;
- Reviewed recent state, regional and national reports to determine possible issues/problems to be explored in the CNMI;
- Reviewed recommendations made by various task forces;
- Identified major data/indicators (including trends) of health status, access, health needs and health disparities to be included in the assessment for each domain; and
- Determined stakeholder and public input processes.

Quantitative methods used for assessing needs for each of the population domains included a review of various the data sources including Vital Statistics Data, U.S. Census Data for the CNMI, Surveillance Systems and Registries, Mortality Reviews, Commonwealth Healthcare Corporation and other CNMI Agency Data and Reports, and Youth Behavior Risk Surveys. Findings were used to guide elements of MCH Public Input Survey.

Public Input Survey

Survey Development

With contribution and approval by the Steering Committee, a survey was developed to gather feedback from stakeholders and service populations on important MCH topics. Beginning in October 2018, MCHB gathered feedback from program staff in their divisions on topics they perceived as the top current or emerging issues among MCH populations. Based on their observations, training opportunities, literature reviews, and interactions with providers and consumers, program staff prepared lists of topics that they perceived as most important to MCH population domains and program implementation.

Survey Dissemination

The electronic survey was directly distributed to 228 contacts in total. Sixty-six (66) of those contacts were across CHCC programs including family planning, newborn screening, immunization and women, infants and children (WIC); 48 were CHCC clinical providers; and 114 were MCHB partners and consumers.

In addition to the direct distribution, the survey was also shared via social media links on What's App, Facebook and email through an indeterminable number of shares. In addition to the electronic survey, a paper survey was available during home visits with families and caregivers.

The survey was open for four weeks in October and November 2018.

Upon completion of the original survey results indicated that no adolescents completed the survey. Therefore, a ten question adolescent-only survey was developed from the original survey asking the adolescent specific questions about health priorities, health beliefs, behavioral health, needs across the lifespan, island of residency, and age group. The survey is included as Appendix 2, Adolescent Public Input Survey, to this report.

Data Analysis

Paper surveys were hand entered electronically for analysis with the online responses. The survey resulted in a large volume of quantitative data. The results were analyzed by focusing on the three topics in each domain the respondents indicated were the highest priority.

Demographic information, priorities, issues of parent education and family engagement, and health beliefs were also analyzed. The data analysis process is described below.

Demographics

The survey asked respondents to identify their role (e.g. parent, health care provider, educator, policy maker, etc.), familiarity with the MCH program and their island of residence. Respondents were also asked to identify their age, race and ethnicity, gender, and education level.

Responses were counted and categorized by role, the island of residence and familiarity with the MCH program. The response rates were calculated for these demographic categories and the highest response rates were identified.

Priorities

There were six questions, one for each domain, that asked respondents to identify their top three priorities. All responses were combined and given equal weight. The ranking of topic chosen within each domain was calculated. The SurveyMonkey-generated data summaries were reviewed and the raw data was cleaned so it did not include any information that did not make sense or appeared to be entered in error. Next, the summaries were reviewed and the top three topics in each domain were identified.

The survey asked stakeholders if there are any issues or services that are important that were missing from the survey. Phrases or responses that showed up more than once were highlighted and that information was used to identify themes. Responses were grouped together by theme.

Parent Education and Family Engagement

A question that asked respondents to identify activities to provide parent education as well as a question that asked respondents to identify strategies for family engagement were included. For each question respondents were allowed to choose up to five responses. The ranking of responses chosen within each question was calculated. The top three responses were identified.

Health Beliefs

There were eight questions that asked respondents to rate their beliefs on the importance and availability of certain health related services within the known domains. The rating of responses chosen for each question within each domain was calculated.

Survey Limitations

Several limitations were identified that potentially had an impact on the methodology and findings.

The timeline for stakeholders to submit feedback through the survey was limited. The survey was open for four weeks. If the timeframe for respondents to submit the survey was open for longer than four weeks, more people could have had an opportunity to complete the survey. In addition, Super Typhoon Yutu, which devastated the islands of Saipan and Tinian, occurred during the survey collection period. Even given these time factors the response rate was ample.

The topics respondents could rank were limited to the list provided by the Steering Committee. The topics identified as priorities may not have been identified as such if respondents could have added topics to be ranked. Although, respondents were asked if there were any issues or services that are important to them that were missing from the questionnaire, what those issues or services are and why are they important, few responses to this question were received (25) and most were related to staffing (9) and behavioral health (8).

The number of topics respondents were asked to rank varied by domain and may have impacted rating scores. If more topics were available to choose from, there may have been less consensus among the respondents.

Unfortunately, Tinian residents were underrepresented, as only two residents of Tinian completed the survey. Rota had fifteen responses but the percentage of representation is proportional to the population.

SWOT Analysis

A Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis was conducted on each domain by the Core Needs Assessment Workgroup, which represents broad and diverse sectors of the MCH Programs.

A SWOT analysis was used to gain insight into MCHB's current and future impact on the healthcare arena. This allowed the Workgroup to see competitive advantages and positive prospects, as well as existing and potential problems, in order to develop appropriate plans to capitalize on positives and address deficits. With SWOT factors identified, decision-makers are better able to ascertain if an initiative is able to be influenced and what is required to make it successful. As such, the analysis aims to help MCH match its resources to the environment in which it operates.

Prioritization of Issues

In keeping with the guiding principles of the process, the Needs Assessment Workgroup and public stakeholders completed the final prioritization process and state capacity assessment to determine the MCH priorities. This process focused on the goal of identifying select areas for MCH investment so that a comprehensive set of interventions could be employed at more depth to affect five-year outcomes.

To gauge capacity, public health management and staff, with input from public stakeholders, were asked to assess their organizational capacity to address the potential MCH priority areas. The following four components were utilized to assess capacity for each of the proposed MCH priorities.

- Structural Resources: Financial, human, and material resources; policies and protocols; and other resources needed for the performance of core functions.
- Data/Information Systems: Access to timely program and population data; supportive environment for data sharing; adequate technological resources to support the use of data in decision-making.
- Competencies/Skills: Knowledge, skills, and abilities of MCH staff.
- Organizational Relationships: Partnerships, communication channels, and other types of interactions and

collaborations with public and private entities.

Following these discussions, each issue was ranked, using a grid specifying impact and feasibility along an x and y axis. This, along with the assessment of state capacity, served as key resources for discussion in determining the final set of eight priorities. The ranking tool is included as Appendix 3, Priority Setting Tool, to this report.

In addition, the chosen priorities needed to be tied to the MCH scope of influence in order to assure ultimate impact. In order to do so, the Steering Committee was charged with connecting each potential priority to a national or population-based outcome measure. To this end, the Steering Committee prepared a justification for each priority highlighting the following: public health/MCH role; data to support the need (severity or numbers affected); effective interventions/strategies that exist to address the issue; local capacity score for the issue and specific indicators that could be used to measure success within the five-year period.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Domain: Women/Maternal

Data Assessment

The CNMI has a very large underserved population who are not receiving recommended annual preventive health services within the community. As in many underserved communities with a high percentage of families living below the federal poverty level, these women face many barriers to care, including, unaware of health needs; shame or fear in seeking reproductive health services; access to care issues; uninsured status; transportation issues; and childcare issues.

In 2017, data review of visits to the Family Planning Program and the CHCC Women's Clinic indicate that just 18.2% of women ages 18 through 44 completed a preventive doctor's visit at CHCC. Screenings are critical in early identification, prevention, and treatment of disease. Diseases of the circulatory system, neoplasms, and diabetes are the top three causes of death for adults, even among women, in the CNMI based on Health and Vital Statistics data for the period of 2008 through 2016. Eighty four percent (84%) of individuals who responded to the 2016 CNMI NCD & Risk Factor Hybrid Survey reported that they avoided medical care due to costs associated with a doctor's visit[1].

The NCD Hybrid Survey indicates that for women ages 21 thru 65 years old, just 43.2% reported being up to date with pap testing as compared to US national average of 69% in 2015 according to the Centers for Disease Control and Prevention National, Center for Health Statistics.

Although there appears a decrease in the number of women screened who were at risk for anemia in 2017, a review of nursing log books at the CHCC hospital OB unit indicates an increase in the number of admissions with an anemia diagnosis indicated. Additionally, OB admissions also indicate an increase in the number of admissions that required blood transfusions. Between the years of 2016 and 2017, there had been an increase in admissions with anemia diagnosis by 47% and an increase in admissions with blood transfusions by 56%. A possible factor that may have contributed in these increases was the implementation of a blood transfusion policy in 2016. In response to a sentinel event, the CHCC had implemented a blood transfusion policy to ensure rapid provision of blood components in correct ratios during hemorrhage circumstances and which provides guidance and protocol in identifying and addressing situations that require blood transfusions.

Domain: Perinatal/Infant

Data Assessment

Recent NOMs and NPMs data describe perinatal/infant health in the CNMI, during the previous two years (2016 and 2017), are as follows:

- Slight increases in ever breastfed from 94.1% to 95.6%;
- Slight increases in percent breastfed exclusively through 6 months from 1.7% to 2.5%, although still quite low overall;
- Increases in perinatal mortality rate to 5.8 per 1,000 live birth, plus fetal deaths from 4.9.

Recent SOMs and SPMs data describe perinatal/infant health in the CNMI, during the previous two years (2016 and 2017),

are as follows:

- Slight increases in first trimester prenatal care for resident women from 43.4% to 45.8%.

The perinatal mortality rate in the CNMI in 2017 was 5.8 per 1,000 live births, see Table 7 below. According to the National Vital Statistics Reports, the most recent national perinatal mortality rate available was 5.77 per 1,000 live births in 2018 quarter 1. CNMI has reduced its perinatal mortality in the past five years and is now consistent with the national rate.

Table 7. Perinatal mortality rate per 1,000 live births plus fetal deaths

	2013	2014	2015	2016	2017
Rate:	12.1	14.0	2.7	4.9	5.8
Numerator:	13	15	3	6	7
Denominator:	1,074	1,075	1,107	1,216	1,209

Source: Health and Vital Records Office

During recent Fetal and Infant Mortality Review, a total of 32 cases were reviewed in which some of the findings included: 41% of the cases had prenatal care initiated during the first trimester of pregnancy; 69% of the prenatal women had a complication or pre-existing health condition; 47% of the cases had three or less prenatal visit and only 6% completed at least ten visits; and almost one-quarter (22%) were uninsured. Recommendations that resulted from the case reviews included: need to include private clinic providers in the review; prenatal records from private clinic providers were lacking; lack of transportation was noted in many of the cases as a barrier to prenatal care; need to focus on engaging women to increase early and adequate care; and a need to focus on Preconception Health (preventive care before and between pregnancies).

Accessing early and adequate prenatal care continues to be a need for all CNMI pregnant women. In 2017, just 46% of pregnant resident women received prenatal care during the first trimester of pregnancy. Lack of transportation, not having insurance, and no child care are top three reasons provided for not going to prenatal care appointments. Eighty-four percent (84%) of individuals who responded to the NCD Hybrid Survey reported that they avoided medical care due to costs associated with a doctor's visit.

Domain: Child

Data Assessment

Recent NOMs and NPMs data describe child health in the CNMI, during the previous two years (2016 and 2017), are as follows:

- Significant increase in children who complete Ages and Stages Questionnaire screening at a CHCC well-visit from 38.4% to 53.6%
- Slight decrease in children aged 1-17 who had a preventive dental visit from 13.6% to 11.9%;
- Increase in dental caries from 55.6% to 58.4%.

Recent SOMs and SPMs data describe child health in the CNMI, during the previous two years (2016 and 2017), are as follows:

- Slight increases in children age 19-35 months receiving vaccines from 33.8% to 39.2%, although low overall;

Although comparison of the past two years' NOM shows an increase in dental caries, it has remained steady when including an additional year of data, as seen in Figure 5: School Sealant Program below. Through a formal partnership with the Public School System, the MCHB Oral Health Program continues to provide school based preventive services to students enrolled in Head Start, and students in 2nd and 6th grade. Students who participate in the Fluoride Varnish or Dental Sealant programs are provided oral health education, oral exams, and fluoride varnish or dental sealant application.

According to Women, Infants and Children (WIC) 2018 data, 22.9% of child participants aged 2 to 5 years old are overweight as defined by the 85th percentile or above and 10.3% are obese as defined by the 95th percentile or above. This is a steady increase in the same population over the past three years, see Figure 6 below.

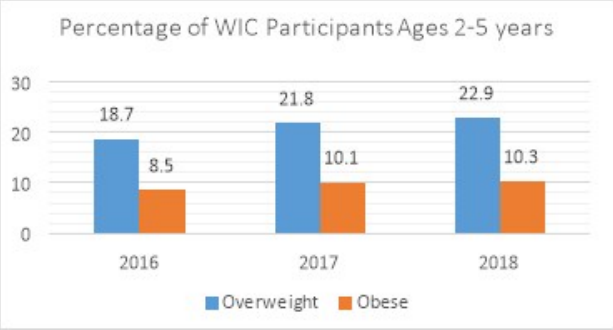


Figure 6. Percentage of Overweight and Obese Children Age 2-5

Source: WIC Program

It is known that onset of overweight in childhood accounts for 25% of adult obesity; but overweight that begins before age 8 and persists into adulthood is associated with an even greater degree of adult obesity. Childhood overweight is associated with a variety of adverse consequences, including an increased risk of cardiovascular disease, type 2 diabetes mellitus, asthma, social stigmatization, and low self-esteem. According to the middle school biennial Youth Risk Behavior Survey, more students describe themselves as overweight, increasing from 26.5% in 2015 to 30.8% in 2017, see Table 9 below.

Table 9. Physical Activity Related Youth Risk Behavior Survey Results, Middle School

Question	2013	2015	2017
Percentage of students who describe themselves as slightly or very overweight	26.9	26.5	30.8
Percentage of students who ate breakfast on all seven days before survey	45.0	51.1	48.0
Percentage of students who were physically active at least 60 minutes per day on 5 or more days a week	45.5	45.5	50.9
Percentage of students who watched television 3 or more hours per day (on an average school day)	32.5	29.1	24.3
Percentage of students who played video or computer games or used a computer 3 or more hours per day (on an average school day)	-	46.6	48.2
Percentage of students who played on at least one sports team in the last 12 months	47.9	53.3	50.4

Source: Source: CNMI Middle School YRBS

Domain: Adolescent

Data Assessment

Recent NOMs and NPMs data describe adolescent health in the CNMI between 2015 and 2017 (based on biennial completion of the Youth Risk Behavior Survey (YRBS) are as follows:

- Slight increase in adolescents aged 12-17 who are bullied from 22.1% in 2015 to 23.3% in 2017.

Recent SOMs and SPMs data describe adolescent health in the CNMI between 2015 and 2017 (based on biennial completion of the YRBS) or during the previous two years (2016 and 2017) are as follows:

- Slight increase in high school students who have thoughts of suicide from 22.8% to 25.0%;
- Steady decrease in pregnancy rates among adolescents aged 15-17 from 16.5 in 2015 and 11 in 2016 to 8.5 in 2017.

Trend analysis for the past three biennial YRBS survey administrations indicate slight increases in the number of high school students that reported being bullied on school property and electronically.

Review of data on the past three years (2015 through 2017) has indicated a steady decline in the rate of teen births, see Table 13: Teen Birth Rates below. This may be due to the steady increase in family planning visits by adolescents in the past several years, seen in Table 14 below. Other possible contributing factors are seen in additional measures on adolescent sexual behavior assessed through the biennial high school YRBS. Review of CNMI high school YRBS data

indicates a decline in most sexual risk measures and an increase in condom use between 2013 through 2017, as indicated on Table 15 below.

Table 13. Teen Birth Rates

Teen Birth Rate per 1000	2015	2016	2017
15-17 year olds	16.5	11.0	8.5
15-19 year olds	30.2	26.9	17.1

Source: CNMI Health and Vital Statistics Office

Table 14. Adolescent Family Planning Visits

Family Planning Visits	2014	2015	2016	2017
15-19 year olds	134	109	250	248

Source: CNMI Family Planning Program

Table 15. Sexual Activity Related Youth Risk Behavior Survey Results, High School

Question	2013	2015	2017
Percentage of students who ever had sexual intercourse	43.0	42.2	33.6
Percentage of students who had first sexual intercourse before age 13	6.9	6.7	4.1
Percentage of students who had four or more sexual partners in lifetime	11.9	10.4	5.9
Percentage of students who had sexual intercourse with 1 or more partners in the last 3 months	29.7	29.0	24.3
Percentage of students who used a condom during last sexual intercourse	45.0	45.8	52.6

Source: Source: CNMI High School YRBS

Domain: Children with Special Health Care Needs

Data Assessment

Recent NOMs and NPMs data describe children with special health care needs in the CNMI, during the previous two years (2016 and 2017), are as follows:

- No change in children with a medical home at 46.8%;
- Slight decrease in children aged 0-17 adequately insured from 59.5% to 57.8%.

MCHB programs have been focused on building a comprehensive and coordinated system of care targeted at ensuring that all children in the CNMI receive appropriate and timely services, including screening, evaluation, diagnosis, early intervention, and family support. Without early identification and intervention, children with special healthcare needs often experience delayed development.

The CNMI Part C: Early Intervention Services (EIS) Program is administered under the Public School System and remains a vital partner for ensuring the children with special healthcare needs and their families receive the necessary services and supports. This partnership is formalized through an existing Interagency Agreement. Identification is done through newborn screenings services, developmental screening, working with providers and nurses who identify conditions to refer, and in educating the community and families regarding developmental milestones and available screening services for concerns. Title V funds are used to support these activities. In 2017, the EIS program received a total of 176 referrals, in which 62 infants and toddlers were qualified for enrollment into the program. Most of the referrals, 26.7%, were from the CHCC children's clinic, 22% from the CHCC nursery, 12.5% from the NICU, and 9% were parent self-referrals. Referrals were also received from the H.O.M.E. Visiting Program, Kagman Community Health Center, WIC, CHCC Pediatrics Unit, Day Care Centers, and the EHDI program.

The CNMI Early Hearing Detection Intervention (EHDI) Program has been improving the EHDI system of care to include partnerships with stakeholders, including: nurses, midwives, physicians, audiologist, public health programs, and the Early

Intervention Services program. The program works to achieve the national recommendation of 1-3-6: screening all babies by one month of age; completing Diagnostic Testing for babies that require it by three months of age; and ensuring that all babies diagnosed as deaf or hard of hearing are enrolled in Early Intervention Services by six months of age. In 2017, 99% of babies born in the CNMI were screened for hearing loss before one month of age.

In 2015, newborn bloodspot screening was reinstated at the Commonwealth Health Center allowing for babies born in the CNMI to be screened for various disorders. In 2017, approximately 50%, or 606, of the babies born in the CNMI received a newborn bloodspot screen. Twenty-seven (27) of those screened had a presumptive positive with three receiving a confirmed diagnosis.

In 2017, 90 children ages three to five years enrolled in Part B: Early Childhood services, and 877 children ages six through 21 enrolled in Special Education (SPED). Data from the Public School System indicates that 40% of the children enrolled in Early Childhood and SPED had specific learning disabilities, 16% identified as having a developmental delay, and 14.5% have autism. See Table 20 below.

Table 20. Disability Category and Enrollment in Early Childhood Services and Special Education, 2017

Category	Enrollment Percent
Specific Learning Disability	40.43%
Developmental Delay	16.07%
Autism	14.53%
Other Health Impairment	10.24%
Intellectual Disability	6.45%
Multiple Disability	5.12%
Hearing Impairment	2.56%
Speech or Language Impairment	1.64%
Emotional Disturbance	1.54%
Orthopedic Impairment	0.61%
Visual Impairment	0.41%
Traumatic Brain Injury	0.31%
Deaf-Blindness	0.10%

Source: Public School System, SY 2016-2017

The Shriner's clinic based in Honolulu, Hawaii provides outreach services on the Northern Mariana Islands twice a year for children ages zero through 18 years with musculoskeletal healthcare needs. Referrals to this clinic are made by a primary care provider or anyone in the community who has concerns. Referrals are managed by the Newborn Screener and Family Support Coordinator under the MCHB, who assists families with scheduling and completing all the required paperwork. The outreach clinic comes to Saipan every six months (January and July) and to Tinian once a year, during the summer. Children from the island of Rota are flown to Saipan. Shriner's provides evaluation and treatment for all children with musculoskeletal conditions in addition to providing orthoses for the torso, upper and lower extremities. If needed, children are referred to the Shriner's Hospital for Children in Honolulu for orthopedic surgeries. In 2017, Shriner's providers saw a total of 196 children and eight were referred for surgery in Honolulu. Additionally, the Shriner's Orthotics provides outreach to Saipan four times a year. A provider comes to Saipan to obtain impressions and then returns after a couple of months to conduct orthotics fittings. Families are provided education on how the orthotic should work, cleaned, and maintained. A total of 38 children were provided orthotics through Shriner's in 2017.

Domain: Cross-cutting/Systems Building

Data Assessment

Data sources for cross cutting issues are difficult to mine as there is no central depository. All data is collected for individual programmatic purposes and often by defined age groups thereby making it difficult to have a full picture of health across the lifespan of the individual and the whole of the community.

The majority of adults in the CNMI has visited a dentist or dental clinic. However, according to the 2016 CNMI NCD Hybrid Survey, only about one-third of adults reported having a dental visit within the past year. Additionally, about two thirds of adults reported having at least one permanent tooth removed because of tooth decay or gum disease.

According to the 2016 CNMI NCD & Risk Factor Hybrid Survey Report, one out of four adults in the CNMI reported to currently smoke cigarettes and one out of five adults reported chewing betel nut. Almost half of CNMI adults report drinking alcohol in the past 30 days, with 3.1% having drunk alcohol every day. In addition, 23% of adults in the CNMI reported binge drinking in the past 30 days (binge drinking is defined as five or more drinks for men and four or more drinks for women in one sitting). Although CNMI adults report smoking cigarettes, the majority (77.8%) report wanting to quit. Among the betel nut chewers, 64.7% report wanting to quit.

Betel nut chewers and alcohol drinkers tend to be the younger adult age groups. Adults 25-34 years old have the highest prevalence of smoking. Additionally, the majority of chewers are between the ages 18 to 34 years old. See Figure 12 below.

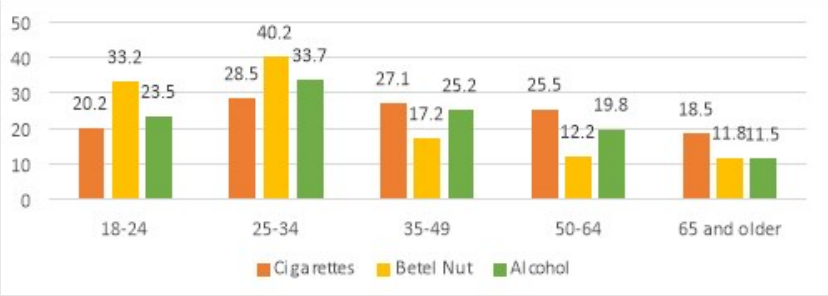


Figure 12. Percent Age Group of Current Cigarette and Betel Nut Users
Source: CNMI NCD & Risk Factor Hybrid Survey Report, 2016

According to the 2013 CNMI Behavioral Health Survey very few people report illegal drug use. The highest use is for marijuana with 22.6% reporting use. For all others the use was below 3%- heroin, crack or cocaine, methamphetamine was 2.6%, inhalants 1.4%, prescription drugs without a physician's order 1.2% and hallucinogens 0.7%.

Services to address substance use disorders and other mental health issues are very limited in the CNMI. The CNMI has experienced an increase in the number of babies with prenatal exposure to methamphetamine. Illicit drug use, particularly methamphetamine, in the CNMI has increased in the past few years resulting in the establishment of the first Drug Court program in 2016 with the Commissioner for the Department of Public Safety proclaiming a "War on Ice" as a response to increase crime rates related to illicit drugs. Data obtained from the CNMI Office of Attorney General indicates an overall increase in the number of criminal cases filed in 2016 as compared to 2015, with a 39 percent increase in the number of drug related cases. While there are numerous efforts around substance abuse prevention, treatment services are lacking.

The 2010 Census reports the CNMI uninsured at 34%; more than double the 15% of the uninsured in the US. Looking specifically at CNMI children, the numbers of uninsured are slightly higher than the overall population, see Table 24 below.

Table 24. Insurance Status of CNMI Children age 1-9 years

Year	Percent Uninsured	Percent with Medicaid
2011	68.4	27.7
2012	60.6	28.5
2013	56.9	38.1
2014	50.0	49.4
2018	35.1	53.3

Source: RPMS, CHCC

As the number of children with Medicaid has almost doubled since 2011, the number of uninsured has decreased by almost half. However, the number uninsured still remains remarkably high at 35% of children. The same improvement in insurance status can be seen in women utilizing the CHCC for medical care, see Table 25 below. However, again the uninsured rate of 40% is well above the national average of 15%.

Table 25. Insurance Status of Women at CHCC

Year	Percent Uninsured	Percent with Medicaid	Percent with Private Insurance
2008	49	27	24
2013	25	55	20
2018	39.9	32.1	28.1

Source: RPMS, CHCC

Medicaid Expansion as part of the Affordable Care Act (ACA) accounts for much of the increase in coverage. However, increases in Medicaid funding to the CNMI under U.S. Public Law 111-148 will currently cease in September 2019 resulting in a 63% reduction in State Medicaid spending. In 2019, the $100.1 million additional funding provided from the PPACA between 2011 and 2019 expires, leaving a funding gap of approximately $11 million annually. This impending resource expiration is a major concern for the CNMI Medicaid Agency and will likely result in increases in uninsured.

Little data exists on topics such as health disparities within the community, behavioral health issues, consumer desired use of technology including telehealth, and preferred communication of health messages.

[1] CNMI Non-Communicable Diseases & Risk Factor Hybrid Survey, 2016 accessed at http://ver1.cnmicommerce.com/wp-content/uploads/2017/04/CNMI-NCD-Survey-Report-FINAL-2017.pdf, on March 11, 2019.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

TITLE V PROGRAM CAPACITY

Organizational Structure

The MCH Program is administered within the Division of Public Health of the Commonwealth Healthcare Corporation (CHCC). In 2012, Public Law 16-51 dissolved the CNMI Department of Public Health and created the CHCC. The CHCC is a semi-autonomous, quasi-governmental corporation. As such, it has a Governor-appointed Board of Directors and in that way is part of the central government of the CNMI.

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, including management of federal health related grants. The Chief Executive Officer of CHCC is the authorized representative for the MCH Program. The Chief Operations Officer provides oversight to the program. The following are senior leadership positions: Ms. Esther Muna, Chief Executive Officer; Mr. Subroto Banerji, Chief Operations Officer; and Mr. Jesse Tudela, Deputy Chief Operations Officer.

The Division of Public Health is responsible for administering the Title V MCH Program. The MCH Program falls under the Maternal Child Health Bureau. The MCH Program is one of the six programs under the Maternal Child Health Bureau along with Family Planning, HRSA and CDC funded Universal Newborn Hearing Screening/Early Hearing Detection and Intervention Programs, Public Health Dental Clinic, H.O.M.E. Visiting, and State System Development Initiative. The Administrator of the MCHB also acts as the MCH Program Coordinator. The development of the MCH Bureau has been a positive asset in that it has improved coordination and collaboration among the programs. *See Attachments: Organizational Chart.*

All MCH services are also provided at the Tinian and Rota Health Centers either directly or through rotating visits. A Resident Director oversees services provided in Rota and Tinian. Two H.O.M.E. Visiting staff are placed on these islands.

III.C.2.b.ii.b. Agency Capacity

Agency Capacity

Women/Maternal Health

Prenatal and Postpartum care, Family Planning services, and comprehensive women's health and gynecological services are provided at the Women's Clinic located at the CHCC, and Rota and Tinian Health Center. There are midlevel providers as well as four obstetricians/gynecologists at the Women's Clinic for referrals of high risk cases such as diabetes and hypertension. Increasing the percentage of women receiving adequate prenatal care visits, especially during first trimester, continues to be a focus for the Division.

The HIV/STD Resource and Treatment Center provides counseling, partner identification and notification, treatment, and case management. Some goals of the program include community testing and mass media campaigns emphasizing behavioral change.

Breast cancer and cervical cancer screening exams such as pap smears, clinical breast exams, and mammograms are provided at no cost to women that meet the Breast and Cervical Cancer Screening Program's criteria.

Perinatal/Infant Health and Child Health

Perinatal health is also described above in Women/Maternal Health prenatal care.

Newborn assessments, well baby/child exams, and adolescent health visits are provided at the Children's Clinic and at the Rota and Tinian health centers. Breastfeeding is also discussed and education for proper technique or identified issues is completed.

Providers at the Children's clinic make referrals to MCHB programs for dental care, hearing screening, early intervention services, specialty clinics, and home visits are made based on assessment findings. The promotion of breastfeeding is actively done during these visits.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program serves to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care. MCH Program partners with WIC on many initiatives including breastfeeding support and encouraging prenatal care.

Newborn Hearing Screening has successfully screened 98% of newborns before hospital discharge. Quality improvement activities are focused on reducing loss to follow-up.

The Immunization Program ensures availability and accessibility of vaccination services. The Immunization Program was transitioned under the MCHB in May of 2020. The Public Health Clinic is open for walk-ins, improving accessibility. The implementation and strengthening of the Web IZ immunization surveillance system, will help improve tracking and case management of children in need of immunizations.

The School Health Program fulfills the local school health certificate requirement for all children entering school for the first time in the CNMI. A school health certificate is issued after a physical examination, including hearing and vision screening, is performed as well as completing the required immunization series for that age group.

The School Dental Program has proven to be one of the most successful collaborations between the Division of Public Health and the school system, both public and private. A dental assistant provides a full mouth examination, fluoride varnish and sealant application, and education at each Head Start facility. In addition to the Head Start Program, every school year children in second and sixth grades in the public and private schools, including Rota and Tinian, are bussed to the Dental Clinic to receive dental services. Services provided include a full mouth examination in which they are assessed for caries and periodontal diseases, sealant application, and education. The children are given report cards on their dental assessments so parents can make necessary appointments for further dental treatment and procedures.

Outside of the School Dental Program, the Dental Clinic provides services that include general dentistry such as sealant application, fluoride tablets, education/counseling, community outreach activities, cleaning, extraction, and fillings. Public

Health, along with four private dental clinic, accepts children enrolled in the Medicaid Program for their restorative treatment needs. The Dental Clinic includes the private clinic information on all brochures to promote access to oral health.

Adolescent Health

Preventive and primary health care services for adolescents: Services provided at Women's Clinic, Children's Clinic, and HIV/STD Resource Center as described above.

The adolescent health focus is on the avoidance of risky health behaviors such as drugs, alcohol, and unsafe sex. The MCH Programs works closely with the HIV/STD Program. In addition, much work for this population is done in collaboration with the Public School System (PSS). Mental health and social services are provided through the Community Guidance Center (CGC).

The CGC promotes positive youth behaviors. The CGC leads underage drinking prevention efforts. It also addresses injury and suicide, violence prevention and has strong ties to the federal, state and community agencies and programs that carry out risky behavior reduction activities. The CGC Garrett Lee Smith Youth Suicide Prevention Program focuses on ages 10 to 24 years old to promote awareness that suicidal and self-destructive behavior is a public mental health problem in order to reduce stigma associated with being a consumer of suicide prevention, increase system-wide capacity to deliver effective suicide prevention and intervention, develop collaborations and networks that support common goals in suicide prevention and improve the usefulness of data surveillance systems to effectively inform suicide prevention and intervention efforts. The CGC Systems of Care focuses on ages 5 to 21 years old to promote the improvement of care and opportunity for youth with and youth at risk of severe emotional disturbances through improved collaboration between youth and family serving groups.

Children with Special Health Care Needs

Services are set up to promote an integrated service delivery system for CSHCN from birth to 21 years of age and their families. The Program works collaboratively and cooperatively with other agencies and departments to provide appropriate education and support services needed to meet their social, emotional, physical, and medical needs. The CSHCN Program has been developed as an interagency effort among the MCH Program, the Hospital, the Special Education Program, and the Early Intervention Services Program.

One priority of the program is to identify these children at the earliest age possible, preferably right after birth. The entry point into care is through referral to Child Development Assistance Center (C*DAC). C*DAC employs special education teachers, social workers, and occupational, physical, and speech therapists for 0-3 year olds. MCH Program employs care coordinators who oversee the coordination of specialty care that the children need.
The program provides transportation, eligibility assistance, and activities such as parent events, health forums, and trainings, to support CSHCN and their families. Challenges for the program include: lack of qualified professionals on-island for specialized services; clients who do not qualify for SSI, Medicaid, etc., because of citizenship status; and limited respite care facilities for families of CSHCN.

Contractual services, such as the audiologist, provide services that are not available otherwise. Specialty teams from Shriner Children Hospital in Honolulu visit CNMI twice a year. These specialized groups provide services in Cardiology, EENT, Orthopedics, and select surgeries. With limited or practically no state-of-the-art medical equipment, compounded with the lack of physicians with specialized skills, CNMI heavily relies on overseas contractors and medical referrals, both of which are very expensive. MCH collaborates with health care providers and the Medical Referral Program to ensure children needing extended care are treated off-island.

Cross-cutting

The Dental Program described above provides services for all MCH populations.

In addition to those mental health activities listed above, MCH works closely with the Community Guidance Center (CGC) for all cross-cutting mental health needs. The CGC's Recovery Clinic, a substance use disorder treatment program, offers services to support individuals and families affected with substance use disorders with essential information and coping skills to pursue health, wellness, and recovery. In 2017, the Recovery Clinic launched Intensive Outpatient (IOP)

Treatment Services for individuals affected by moderate to severe substance abuse disorder. Through the Matrix Model, participants and their families are provided structured, evidenced-based treatment for 16 weeks and 36 weeks of continuing care. Alongside the Matrix Model, CGC offers peer support and 12 Step facilitation which builds and empowers participants and their families in the ongoing recovery process.

The CGC's Victims of Crime Advocacy (VOCA) Program's purpose is to support the provision of services to all victims of crime, whether reported or not, in the CNMI. Services include response to the emotional and physical needs of crime victims, help for primary and secondary victims of crime stabilize their lives after victimization, assistance of victims to understand and participate in the criminal justice system, and to provide victims of crime with a measure of safety and security. Counselling services available to victims of crime include counselling for secondary trauma, domestic violence, depression, panic disorders, suicide ideation, and physical, emotional and/or sexual abuse.

MCH works closely with the Medicaid office to promote eligibility and enrollment. A designated MCH staff member provides assistance in filling out Medicaid applications, assists with expediting application processing, and also provides translation assistance for those with limited English.

MCHB continues to improve data capacity. The CNMI MCH State Systems Development Initiative (SSDI) Project continues to focus grant resources to improve data capacity for the CNMI Title V MCH Block Grant program including: the 5 year comprehensive needs assessment, development and tracking mechanisms for ESMs, and data gathering and analysis on NPMs, SPMs, and NOMs. Additional information available in section III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts of this report.

III.C.2.b.ii.c. MCH Workforce Capacity

Workforce Capacity

The MCHB management and team are committed to promote the strategic mission and values of the organization by developing a culturally competent and diverse workforce. To address the shifting demographic trends in the population served, each program within the Bureau works closely with key stakeholders and consumers to understand and manage the social and cultural differences of target groups.

The MCH Bureau is administered under the leadership and direction of the Chief Executive Officer, Esther L. Muna. Direct oversight is provided by the Chief Operations Officer, Subroto Banerji. The following key personnel provide support and coordination:

MCH Program Coordinator/MCH Bureau Administrator: Heather Santos Pangelinan, MS.
SSDI Project Coordinator: Richard Sablan, BS.
MCHB Fiscal Specialist: Maxine Pangelinan, MBA.
MCH Services Coordinator: Mr. Yarobwemal, MS.
Children with Special Health Care Needs Coordinator: Danielle Youn Jung Su, MS, CRC.

The following is a listing senior level management and key staff involved in the Title V needs assessment and application processes although not directly supported by Title V funds.

Department Chair of Pediatrics: Elizabeth Triche, MD, MPH.
CHCC Dental Clinic Dentist: Dr. Angelica C. Sabino, DDS.
OB/GYN Physician/Family Planning Program Medical Director: Michael Deary, MD.

The MCH Programs continue to provide coordination and provision of outreach clinic services, education and awareness, data collection and reporting, and other services aimed at improving the quality of life for our MCH population. The programs administered under the CNMI MCHB continue to meet major milestones and objectives. The following are key MCHB staff:

Family Planning Program Manager: Crystal Pangelinan, MS.
H.O.M.E. Visiting Project Coordinator: Yuline C. Fitial, BS.
Newborn Screener and Family Support Coordinator: Shiella Marie Perez, ASN.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

KEY PARTNERSHIPS

The MCH Program has been instrumental in forging strong partnerships to enhance disease prevention and public awareness activities. Other strategies to strengthen the MCH Program's capacity to promote and protect the health of the target population are: 1) work with schools to ensure children enrolled are up to date with their immunization and on nutrition and physical fitness activities; 2) work with partners during island-wide community events which will strongly emphasize lifestyle behavioral changes especially with health care practices, diet, and physical fitness; 3) develop partnership with other agencies to ensure continuity of care; and 4) support partnerships with internal clinical providers/partners to enhance the public health- clinical collaboration for the provision of population based and enabling services and programs. The strength of MCH Program's work is through collaboration with partners.

Below is a list of partnerships along with corresponding MCH population groups supported:

Agency Name	MCH Population Group
Early Intervention Program (Public School System)	CSHCN
Special Education Program (Public School System)	CSHCN
Breast & Cervical Cancer Screening Program	Women/Maternal Health
Title X Family Planning	Women/Maternal Health & Adolescent Health
HIV/STD Prevention Program	Women/Maternal Health & Adolescent Health
Personal Responsibility Education Program (Public School System)	Adolescent Health
Community Guidance Center (Substance Use and Behavioral Services)	Cross-Cutting
Non-Communicable Disease Bureau (NCD Prevention)	Cross-Cutting
Kagman Community Health Center (FQHC)	Cross-Cutting
WIC	Women/Maternal & Infant Health
Immunization Program	Child Health
HVSO	Cross- Cutting
CHCC Women's Clinic	Women/Maternal & Infant Health
CHCC Dental Clinic	Cross-Cutting
CHCC Children's Clinic	Infant, Child, and Adolescent Health
Northern Marianas College	Cross-Cutting

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

PRIORITIES AND LINKAGE TO NATIONAL PERFORMANCE MEASURES

Feedback received in response to the needs assessment and priority survey was helpful in identifying issues impacting MCH populations in the CNMI that stakeholders consider a priority. The state priorities that emerged are summarized below. A comparison of the 2015 priorities and new priorities is also provided in this section as well as the linkage to National Performance Measures.

Several themes arose from the findings, including access to direct health services, prevention, access to social and support services and awareness of community resources. Access to direct health services is seen in the well-woman, prenatal care and well-adolescent visits. Prevention is apparent in prevention of obesity through physical activity and nutrition, prevention of infant mortality through adequate prenatal care, and prevention of suicide through coping skills. Findings indicated healthy coping skills are also a protective factor that can reduce the likelihood of youth developing addictions and increase their chances of becoming healthy, functioning adults. Social and support services are important to support transition to healthy adulthood, breastfeeding, and navigation of coordinated care systems. Another key finding was stakeholders identified the community as critical in impacting the health status of MCH populations and viewed awareness of community resources as a priority. Community resources was a topic that was identified by stakeholders to be one of the top priorities across all domains. Identification and use of community resources can be seen in the navigation of care in the CSHCN domain and in home visiting in the maternal, infant and child domains. Supporting individuals, families and communities to make changes that would make it more likely for youth to be healthy and successful in both the adolescent and CSHCN domains.

PRIORITIES

PRIORITY 1

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

Domain: Women/Maternal

Priority 1 reflects MCHB's commitment to the MCH guiding principles and current work by addressing the clinic processes as the best way to reach positive outcomes. 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 state. MCHB already has successful partnerships, resources and services yet is now in a better 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.

PRIORITY 2

Education and support to help with breastfeeding

Domain: Perinatal/Infant

MCHB remains committed to the current work of promoting breastfeeding as a means of impacting infant health and throughout the life course. By strengthening existing successes of partnerships with WIC program, MCHB can continue to strengthen the guiding principle of collaboration and creating community change. The following actions are addressed in this priority: collaboration with partners, community education, and increased access to private breastfeeding spaces for the working mother.

PRIORITY 3

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

Domain: Perinatal/Infant

Priority 3 reflects MCHB's commitment to current work by addressing the clinic processes as the best way to reach positive outcomes. The following actions are addressed in this priority: uniform screening, coordinated care, increased access to care through extended hours and additional locations, increased prenatal visits, and access to transportation. Taken together, these needs can be addressed through existing programs as well as new initiatives and contribute to the whole health of the child beginning prenatally and throughout the life course.

PRIORITY 4

Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity

Domain: Child

Discussions during the needs assessment 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 deserts in CNMI was discussed. Some families rely on a small convenience stores due to transportation barriers and/or locale, thus connecting other daily issues (poverty, work schedules, children home alone) to unhealthy food choices. Physical activity is impacted by community issues related to neighborhood planning and development and transportation barriers to organized sports. Participants and staff suggested the importance of aligning with existing programs, including home visiting programs, sporting events, schools, and community campaigns, to promote nutrition education and physical activity.

PRIORITY 5

Coping skills and suicide prevention

Domain: Adolescent

Life skills development such as budgeting, cooking, job training and healthy recreation are also important objectives under this priority. The need to promote positive coping mechanisms can be accomplished with yearly mental health screenings that can lead to suicide prevention and addressing bullying/bullies. Preventative health well visits for adolescents which are fully covered under insurance can promote overall physical health (immunizations, healthy eating, and oral health) as well as social emotional health. 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. MCHB can support schools and faith based organizations to provide the whole family with education and public awareness campaigns, and implementation of policy and procedures can be explored to address bullying and promote suicide prevention.

PRIORITY 6

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

Domain: Children with Special Health Care Needs

This priority is specific to the needs of children and youth with special health care needs, though not exclusive, as it addresses all children in the way that MCHB 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 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 MCHB promotes and is willing to sustain so that all children with health care needs are children first.

PRIORITY 7

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

Domain: Adolescent and Children with Special Health Care Needs

Priority 7 was identified to address the overall needs related to transition in the territory. Empowering individuals to coordinate their own health care was approached as a priority for both adolescents and children with special health care needs so that every youth can understand and practice self-care as well as have a continued awareness into adulthood. Participants stated that understanding the importance of personal health, seeking services, and navigating the health care system promotes lifelong habits for well-being. In addition, empowering youth to enter to adult life with the skills and resources for success throughout life and contributing to the community promotes lasting achievement. Data on this priority is lacking and current resources unknown, therefore assessment of current status will be of primary importance.

PRIORITY 8

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

Domain: Cross-cutting

The needs assessment process indicated that lack of resources were contributing to stressors across all population

domains. Lack of services were an issue, but the bigger issue was lack of knowledge of services. This systemic issue suggests the need for trained, qualified professionals to deliver services across the MCH population domains. Seeking the appropriate care for the maternal and child health care population is critical to ensure that the population needs are being met. For quality care to be delivered it's important that the professionals interfacing with this population are properly trained to provide this care. Ensuring professionals that serve the MCH populations have adequate training impacts individuals from birth and continues throughout adulthood.

Comparison to Previous Priorities

The comparison to prior priorities identified in 2015 is slightly different. The MCH program took a more detailed view of the priorities to improve overall health through specific actions. Below is a table of the old priorities compared to the new with notations of changes.

Table 30. Comparison of Current and Previous Priorities

Current Priority- 2020	Previous Priority- 2015	Notes
Women/Maternal		
Access to health services- ability to find and see a doctor when needed	Improve women's health through cervical and breast cancer and anemia screening	Both years' priorities are based on well-woman care but the current is based on access instead of specific screenings
Perinatal/Infant		
Education and support to help with breastfeeding	Improve perinatal/infant health through early and adequate prenatal care services and promoting breastfeeding and safe sleep	Both years' priorities support breastfeeding and prenatal care
Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care		
Child		
Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity	Improve child health by increasing vaccination and developmental screening rates	New priority
	Improve oral health of children	
Adolescent		
Coping skills and suicide prevention	Improve adolescent health by promoting healthy adolescent behaviors to reduce risk behavior (i.e. drug use, alcohol, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).	More specific priority toward suicide prevention
Children with Special Health Care Needs		
Helping parents/caregivers navigate the health care system for coordinated care	Provide a medical home for children identified as having a special health care need	More specific priority to navigate the medical home
	Improve identification of CSHCN through screening for developmental delays	
Adolescent & 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		New priority
Cross-Cutting		
Professionals have the knowledge and skills to address the needs of maternal and child health populations	Improve insurance status of children and pregnant mothers	New priority

Linkage to National Performance Measures

The CNMI selected the following six National Performance Measures and two State Performance Measures in relation to the identified priority areas.

Table 31. Priority Linkage to National and State Performance Measure

Priority	Performance Measure
Women/Maternal	
Access to health services- ability to find and see a doctor when needed	#1 Well-woman visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Perinatal/Infant	
Education and support to help with breastfeeding	#4 Breastfeeding: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care	There is no corresponding NPM for this priority. The state measure will be percent of resident women who had first trimester prenatal care.
Child	
Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity	#8 Physical Activity: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Adolescent	
Coping skills and suicide prevention	#10 Adolescent well-visit: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
Children with Special Health Care Needs	
Helping parents/caregivers navigate the health care system for coordinated care	#11 Medical home: Percent of children with special health care needs, ages 0 through 17, who have a medical home
Adolescent & 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	#12 Transition: 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
Cross-Cutting	
Professionals have the knowledge and skills to address the needs of maternal and child health populations	There is no corresponding NPM for this priority. A state performance measure will be developed.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$458,614	$463,450	$457,947	$463,007
State Funds	$0	$170,866	$0	$0
Local Funds	$0	$0	$0	$0
Other Funds	$443,825	$434,011	$469,527	$425,131
Program Funds	$0	$0	$0	$0
SubTotal	$902,439	$1,068,327	$927,474	$888,138
Other Federal Funds	$1,703,040	$1,574,778	$1,657,040	$664,388
Total	$2,605,479	$2,643,105	$2,584,514	$1,552,526

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$463,450	$465,091	$465,091	
State Funds	$0	$0	$0	
Local Funds	$0	$0	$0	
Other Funds	$474,700	$517,315	$475,634	
Program Funds	$0	$0	$0	
SubTotal	$938,150	$982,406	$940,725	
Other Federal Funds	$2,059,790	$3,047,227	$2,660,090	
Total	$2,997,940	$4,029,633	$3,600,815	

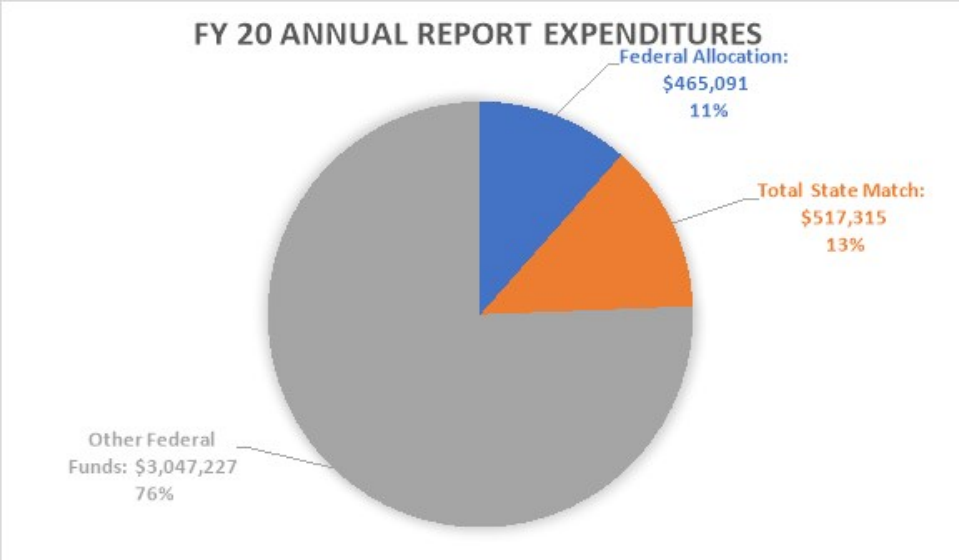
	2022	
	Budgeted	Expended
Federal Allocation	$466,540	
State Funds	$0	
Local Funds	$0	
Other Funds	$487,995	
Program Funds	$0	
SubTotal	$954,535	
Other Federal Funds	$10,877,895	
Total	$11,832,430	

III.D.1. Expenditures

Overview of Expenditures:

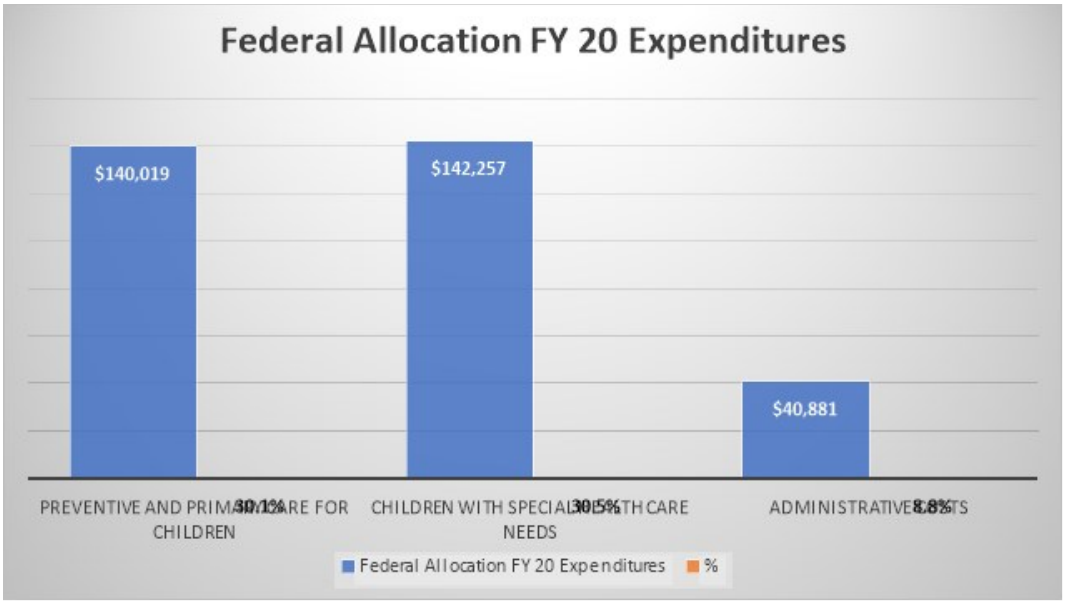
The mission of the CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and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

During the Project Year 2020, from 10/01/2019 through 08/30/2021, the MCH Program expended total funds of $352,657. As of August 30, 2021, the current encumbrance figure is $10,977 and the total unobligated amount is $101,457. Of the total unobligated amount of $101,457, $44,604 is allocated for Wages, Salary and Fringe Benefits, $12,340 is allocated for Administrative Costs, $10,000 is allocated to support the cost for Medsphere Carevue contract and then remaining funds of $34,513 is allocated for supplies and other categories. Therefore, the program is projecting to expend all funds under the grant award by the end of the project and budget period.



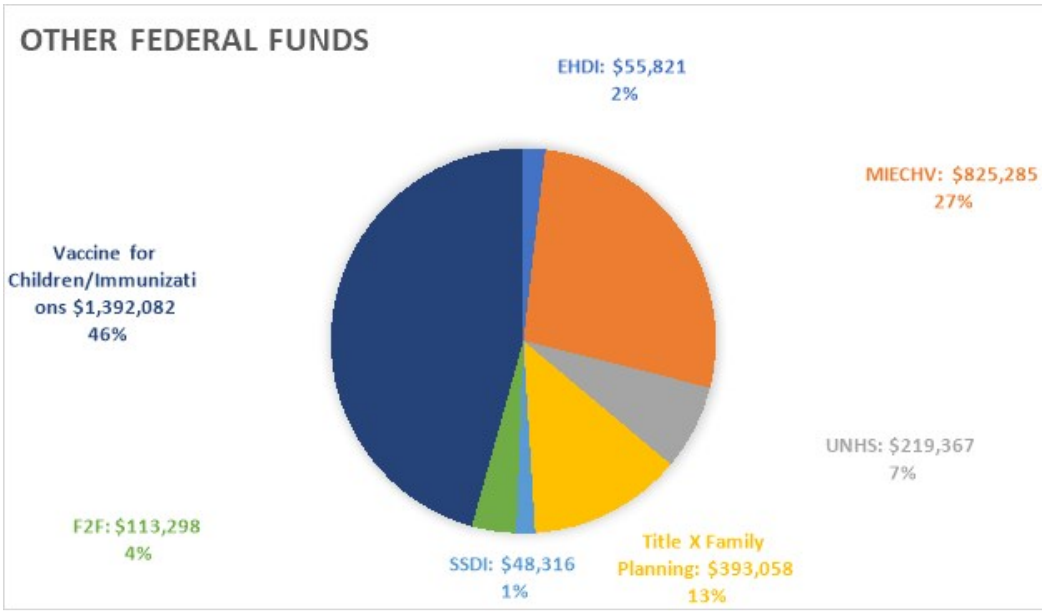
Legislative Requirements Met:

The CNMI Maternal, Infant, Child & Adolescent Health (MICAH) Programs is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. The Fiscal Specialist provides the MICAH Administrator a monthly fund status report that consist of current funds available, funds encumbered, funds expended and the legislative required 30-30-10 percentage status report. The Fiscal Specialist develops the Title V Block Grant Budget and continuously monitor and track expenditures to ensure compliance with the legislative financial requirements. Expenses are monitored and tracked through the state's accounting system called the, *JD Edwards*. The Title V legislation requires a minimum of 30% of the block grant funds to be utilized for preventive and primary care for children and a minimum of 30% of the block grant funds for services for CSHCN. In addition, no more than 10% of the grant may be used for administration costs. The CNMI MCH Program has met the required legislative percentages for FY 20. The chart below provides an overview of the required federal allocation for the FY 20 expenditures.



Other Federal Funds:

The chart below provides an overview of the Other Federal Funds expended that were under the direct authority of the MICAH Administrator which are also listed in Form 2 [Early Hearing and Detection and Intervention (EHDI) State Programs, Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, Universal Newborn Hearing Screening and Intervention Program (UNHS), Title X Family Planning, State Systems Development Initiative (SSDI), Family Professional Partnership/CSHCN (F2F), and the Vaccines for Children/Immunizations]. The Other Federal Funds total expenditure is $3,047,227.



Total State Match:

The Total State Matching funds in the amount of $517,315 was expended for FY 2020. 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

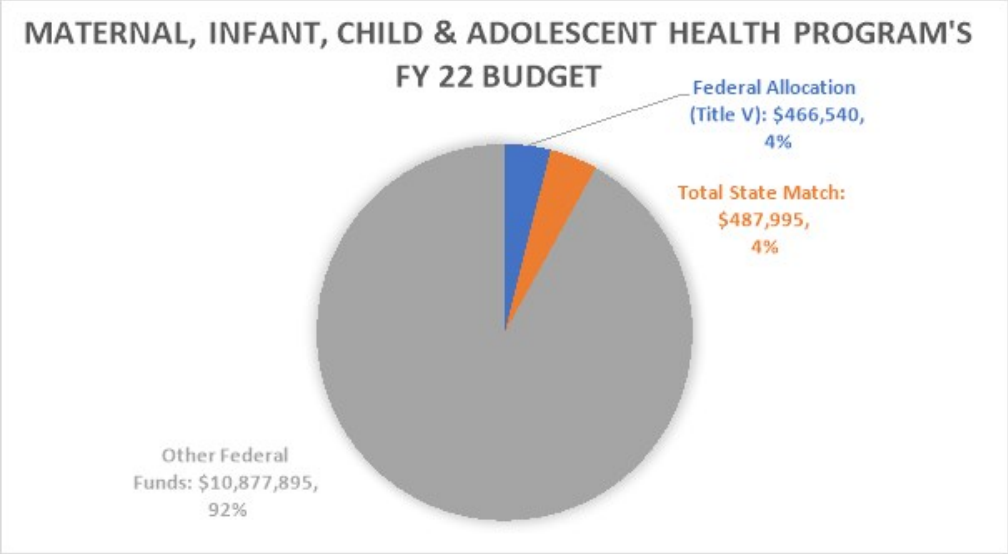
Budget Overview:

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 2022 estimating a total state MICAH Programs budget of $11.8M.

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 Services Coordinator, Child and Adolescent Health Coordinator, 2 Early Intervention Services Workers and an additional Service Coordinator. In addition, the MCH Program cost shares with other MICAH federal program funds to support the following staffing: the MICAH Administrator, Fiscal Specialist, SSDI Coordinator, Outreach Worker and the MICAH Administrative Specialist. The MICAH Administrator is funded 70% under the Title V block grant and 30% under the Immunization and Vaccines for Children. The Fiscal Specialist is funded 50% under the Title V funds, 45% under the ACA Maternal, Infant Early Childhood Home Visiting funds and 5% under the Family Professional Partnership/CSHCN funds. The SSDI Coordinator is funded 4% under the Title V funds and 96% under the MCH Data System Linkage and Training Initiative grant. The Outreach Worker is funded 50% under the Title V funds and 50% under the ACA Maternal, Infant Early Childhood Home Visiting funds. The MICAH Administrative Specialist is funded 19% under the Title V funds and 81% under the ACA Maternal, Infant Early Childhood Home Visiting funds.

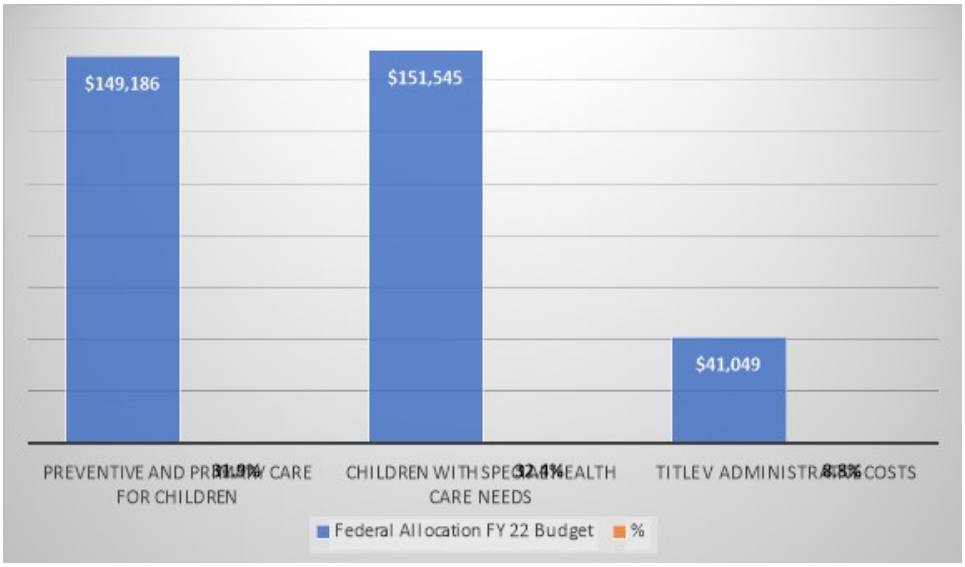
In addition to personnel salaries and fringe benefits, the Title V funds are budgeted towards Public Education and Awareness, Supplies and All Other Costs to support the MCH Programs activities and initiatives stated on the State Action Work Plan. For instance, public education and awareness costs include 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, oral health care, breast feeding, and women's health services. 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, communication costs, office space rental, and et cetera.

The chart below provides an overview of the CNMI MICAH's FY 2022 Budget as reported on Form 2.



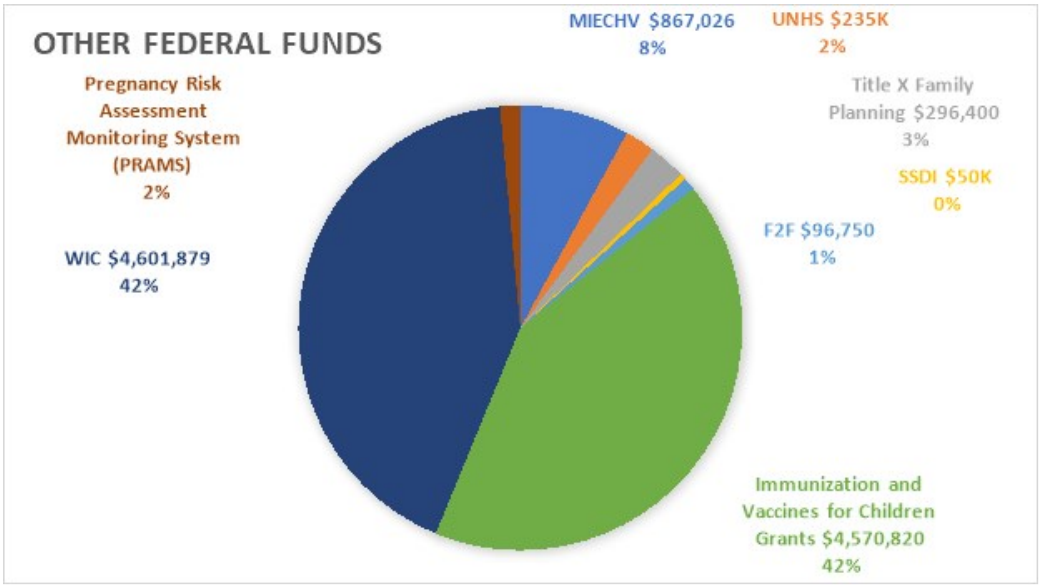
Legislative Requirements Met:

The CNMI MICAH Programs is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. As stated, the MCH Title V funds 50% of the Fiscal Specialist FTE. One of the major duties and responsibilities of this FTE is to continuously ensure that the funds are being budgeted and expended per the minimum required 30-30-10 percentage. The Fiscal Specialist provides the MICAH Administrator a monthly fund status report that consist of current funds available, funds encumbered, funds expended and the legislative required 30-30-10 percentage report. The Fiscal Year 2022 Title V Block Grant budget proposal of $466,540 consist of the following types of individuals served: Pregnant Women and Infants less than 1 year of age was budgeted at $75,760 which is at 16% of the total federal award. Preventive and Primary Care for Children was budgeted at $149,186 which is at 31.9% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Children with Special Health Care Needs was budgeted at $151,545 which is 32.4% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Administrative costs was budgeted at $41,049 which is 8.8% of the total direct costs of the federal grant award. A total of $49,000 was budgeted for All Other Costs such as travel, dues and subscriptions, repairs and maintenance, communication services, office space rental and utilities. The chart below provides a budget overview of the required federal allocation for the FY 22 Budget.



Other Federal Funds:

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



The Other Federal Funds under the control of the MICAH Administrator is responsible for the administration of the Title V program budgeted for the total amount of $10,877,895.

Total State Match:

The MCH match is budgeted at $487,995 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 $954,535. The Total State Match funds are budgeted towards personnel salaries and fringe benefits for staff at the Commonwealth Healthcare Corporation that provides direct services to the MCH population. Since the State Match funds contribute to direct services, majority of the Title V funds contribute to enabling services and public health services and systems.

III.E. Five-Year State Action Plan

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

State: Northern Mariana Islands

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

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

The CHCC Maternal and Child Health Bureau was formed in 2014 to address the needs of the CNMI MCH population, transformation of the MCH Title V Block Grant, and link all opportunities between MCH programs to work through challenges common across programs since the transition of the Corporation into a semi-autonomous agency. In 2021, the MCHB was restructured into the Maternal, Infant, Child and Adolescent Health (MICAH) section, with WIC and Immunization services integrated within the unit. 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.

Beginning in the latter part of 2019, the MCHB, along with other population health programs under the CHCC, initiated efforts for a health system redesign in which a clinical integration approach for impacting population health was adopted. 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 populations. This approach 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.

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 consolidation of MCH serving programs was done in 2014 to address the needs of the CNMI MCH population, transformation of the MCH Title V Block Grant, and link all opportunities between MCH programs to work through challenges common across programs since the transition of the Corporation into a semi-autonomous agency. While most of the staff is funded by sources other than Title V, all contribute to the Title V mission and MCH priorities. For example, a substantial number of MICAH staff work within the Healthy Outcomes for Maternal and Early Childhood Visiting Program, carrying out the implementation of the CNMI HOME visiting work plan.

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.

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 after 2019 but was subsequently granted and extension by US legislation through 2029. Nursing positions are the most difficult to fill due to a national workforce shortage in this specific field. The CNMI, like many US states and other jurisdictions and territories, recruits a large majority of its nursing workforce from the Philippines. However, due to annual reduction in available CNMI conditional worker permits until the program eventually phases out in 2029, the CNMI faces increasing challenges in recruiting and retaining nurses. Various industries compete for these limited number of permits and as such the healthcare field, and CHCC in particular, competes with both public and private agencies across the CNMI. The CNMI also faces challenges in recruiting medical providers. Due to CMS Conditions for Participation, CNMI regulations require that medical providers be US trained or US board certified in order to be licensed providers in the CNMI and this has limited recruitment to the US mainland. The CNMI's geographic location and distance from the US mainland poses as a challenge for recruiting medical providers and turnover is high.

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

The CHCC has been working diligently in implementing strategies to support workforce retention. Standardization and updating of employee classification scales, recruitment tools such as pre-employment skills assessments, and a

focus on performance improvement and professional development are key advances. To support these efforts, the CHCC has expanded its HR team to include a Recruitment Manager and Retention Manager.

Training

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

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

The need to build and improve the workforce for sustainability of the population health programs is imperative to improving delivery of services to the community. The shortage of local manpower impacts health service delivery in that there is a need to recruit manpower from the U.S. mainland. This recruitment process is lengthy and at a high cost for CHCC plus the turnover rate is high. One of the goals of CHCC is to establish a sustainable healthcare manpower program. The CHCC administration is focused on developing competent, committed and compassionate MCH professionals. The CHCC works closely with the Northern Marianas College school of Nursing and has a robust clinical rotation partnership for nursing students to gain training through clinical rotations throughout the health system.

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

- Lactation/Breastfeeding Training
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Motivational Interviewing
- Infant and Child Oral Health (Fluoride Varnish and Silver Diamine Fluoride) Training
- Routine Childhood Vaccination Administration
- Vaccine storage and handling
- Contraceptive Counseling
- Ages & Stages Questionnaire, 3rd Edition, Developmental Screening Training

- Infant Safe Sleep
- Group Prenatal Care

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

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

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

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

MICAH related advisory committees with family partners as members include the: Interagency Coordinating Council (ICC). Early Hearing Detection & Intervention (EHDI) Advisory group, CSHCN stakeholder group, H.O.M.E. Visiting Community Advisory Board, Governor's Council on Developmental Disabilities, and the Head Start Advisory Council. Families and community members also take active roles in the planning and coordinating of annual CNMI wide events.

In addition to these efforts, MCH consults with the national Family Voices organization on strategizing ways to build self-advocacy and leadership capacity among parents and families who have children with disabilities. The MCH proposed and received grant funding to implement a Family-to-Family Health Information Center in the CNMI. The first year was spent as a planning year, which included a needs assessment to determine what the community hoped for with the center and an ideal location for the center. In response to the community's input, the F2F HIC was opened in December 2019 at a centralized location where families can easily have access to. Family-centered services are provided to CSHCN families to best support their children's needs. Assistance, training, and support groups are provided by a Family Support Specialist.

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 Haanshoten 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.
An outline of staff members responsible for data analysis and data systems for MCH include:

Epidemiologist: Emily Haanshoten, MPH. The CHCC Epidemiologist position was recruited through funding made available by the CDC Foundation and the position sustained through the CHCC Epidemiology and Laboratory Capacity (ELC) Program. Emily has a Bachelor's in Public Health from the University of Alabama at Birmingham and a Master's in Public Health Epidemiology from the Arnold School of Public Health, University of South Carolina. The CHCC Epidemiologist is involved in organizational surveillance, data collection, and analysis including those focused on MCH. Recently, Emily was involved in the development of the PRAMS protocol as part of efforts to implement the Pregnancy Risk Assessment Monitoring System (PRAMS) in the CNMI.

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

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

and utilization of the immunization registry, the Weblz. Mr. Santos provides oversight of data staff, oversees the maintenance activities of the registry, monitors data quality, generates data reports and tabulations, and works with various federal, national, and regional partners such as the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), American Immunization Registry (AIRA), and others.

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

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

The Commonwealth of the Northern Mariana Islands (CNMI) Maternal and Child Health (MCH) Systems Development and Improvement (SSDI) Project continue to expand the data capacity for the CNMI Title V MCH Block Grant program. The SSDI Project continues to lead data collection and analysis efforts for MCH health indicators to include all National Outcomes Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs) and Evidence-based or Informed Strategy Measures (ESMs). The SSDI project worked closely with MCH program coordinators at developing data collection tools, and identifying data sources for selected priorities relating to the CNMI 2020 MCH Needs Assessment and CNMI Title V MCH National Performance Measures (NPMs) targeted for the 2021 – 2025 reporting period.

The SSDI Project Coordinator collaborates with CHCC Chief Operation Officer, along with other CHCC Program Coordinators for formulating a data council and developing a data governance framework that addresses data management, data quality and access, data security and privacy, including the development of a centralize Public Health data repository.

Additionally, the SSDI project works with CHCC data visualization contractors for providing MCH data and making it accessible for graphical and to enhance informed-decision making for both Internal and external programs, partners, and stakeholders.

The SSDI works closely with CHCC Corporate Officers including Health Information Technology (HIT) for addressing gaps in data analytics, updating electronic health records, and to increase capacity building for dealing with rapid changes in health care demands and delivery systems.

CNMI MCH Data Sources

Data Source/Program Report	Information Gathered
Maternal and Child Health Jurisdictional Survey	NOM - 1, 4, 6, 14, 17.1, 17.2, 17.3, 17.4, 18, 19, 20, 21, 24, 25 NPM – 1, 4a, 5a, 6, 7.1, 7.2, 8.1, 8.2, 9, 10, 11a, 11b, 12a, 12b, 13.1, 13.2, 14.1, 14.2, 15
Healthy Outcomes for Maternal and Early Childhood (HOME) Visiting Program	Breastfeeding Rates Safe Sleep Practices/data Early Childhood Developmental Screening
Family Planning Program	Preventive Visits for Women ages 18-44 Adolescent Visit Rates
Breast & Cervical Cancer Screening Program	Breast and Cervical Cancer Screening Rates

CNMI Cancer Registry	Cancer Diagnosis Rates
Immunization Program	Childhood Immunization Rates
Early Hearing Detection & Intervention (EHDI) Program	Newborn Hearing Screening Rates Diagnosis and Referral Rates
Public Health Dental Clinic/Oral Health Program (School Based Programs)	Dental Caries Rates Preventive Dental Visit Rates for Children Prenatal Preventive Visit Rates Oral Cancer Screening Rates
CNMI Health & Vital Statistics Office	Birth Rates Teen Birth Rates Preterm Births Prenatal Care rates Fetal & Infant Death Maternal Morbidity & Mortality Data Birth weight data Congenital Anomalies Birth Outcome Data
CNMI Medicaid Office	Number of children enrolled Number of pregnant women enrolled
CHCC Hospital Electronic Health Record Data System	Anemia Diagnosis Rates Well-Child Visit Rates Preventive Visit Rates
Women, Infant, Children (WIC)	Breastfeeding Rates Early Childhood BMI data Anemia screening data
Early Intervention Program	Number of CSHCN 0-3 years
Public School System	Youth Risk Behavior Survey (YRBS) SPED enrollment rates School Enrollment Rates

Recent Priorities and Accomplishments of the SSDI Project Include:

Electronic Health Record (EHR) System Transition

The SSDI Project Coordinator participated in monthly Electronic Health Records (EHR) committee meetings as part of organizational efforts for identification of issues and modifications for improvement for retrieving demographic and clinical information. The EHR is an integrated system used across inpatient hospital units, the emergency department, outpatient clinics, laboratory, and public health programs. As a member of the committee, the SSDI Project contributes feedback and recommendations for obtaining data from EHR and patient registries to inform the Title V MCH annual reports, CNMI MCH 5 – Year Needs Assessment, and to improve the quality of MCH data. Additionally, the SSDI Project Coordinator, along with other MCHB Program Coordinators, are involved in discussions and planning of implementation efforts for transition into a new EHR system to be implemented at the end of 2021. The EHR system is a significant source of data for MCH performance measures and indicators.

2020 MCH 5-year Comprehensive Needs Assessment

The CNMI's MCH 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 strategies measures to improve health outcome of the people in the CNMI. The CNMI five-year needs assessment groups consisted of the following Public Health staff members:

Needs Assessment Steering Committee

Administrator for the Maternal & Child Health Bureau, Heather Pangelinan
SSDI Project Coordinator, Richard Sablan

Core Needs Assessment Workgroup

HOME Visiting Project Coordinator, Yuline Fitial
HOME Visiting Supervisor, Zinna Agulto
Family Planning Program Manager, Crystal Pangelinan
Newborn Screener and Family Support Coordinator, Shiella Perez
Child Health Coordinator, Danielle Su
SSDI Project Coordinator, Richard Sablan
MCHB Administrator, Heather Pangelinan

Needs Assessment Coordinating Committee

Early Intervention Service Coordinator, Dolores Itibus
MCHB Program Assistant, Jennalyd Babauta
Early Hearing Detection and Intervention (EHDI) System Admin, Vacian Pangelinan
HOME Visiting Supervisor, Lena Wabol
SSDI Project Coordinator, Richard Sablan

The SSDI Project collected and analyzed the previous 5-year cycle (2016 – 2020) of MCH programmatic data for the five (5) MCH population domains; (Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health and Children with Special Health Care Needs); with at least one National Performance Measure (NPM) per MCH domain to satisfy the Title V application/annual report requirements. Table 1 and Table 2 illustrates key findings for selected NOMs and NPMs; and SPMs and ESMs respectively.

Table 1: Trend Analysis of the Selected NPMs and NOMs from 2016 to 2020

CNMI MCH TREND ANALYSIS, 2016 to 2020									
	NATIONAL OUTCOME MEASURES (NOMs)	DATA	2016	2017	2018	2019	2020	Avg	Outcome / % change
NOM 1	Percent of pregnant women who receive prenatal care beginning in the first trimester	HVSO	41.9	52.2	49.4	47.9	55.0	49.3	▲31.3
NOM 4	Percent of low birth weight deliveries (<2,500 grams)	HVSO	7.8	7.6	10.9	6.2	10.4	8.6	▲33.3
NOM 6	Percent of early term births (37,38 weeks gestation)	HVSO	27.2	33.4	30.6	26.2	28.1	29.1	▲3.3
NOM 14	Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	CHCC Dental	55.6	58.4	67.1	56.6	64.6	60.5	▲16.2
NOM 20.2	Percent adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	16.0	16.4	16.4	21.6	21.6	18.4	▲35.0
NOM 21	Percent of children, ages 0 through 17, without health insurance	CHCC RPMS/EHR	23.7	42.2	41.3	35.6	28.7	34.3	▲21.1
	NATIONAL PERFORMANCE MEASURES (NPMs)	DATA	2016	2017	2018	2019	2020	Avg	Outcome / % change
NPM 1	Percent of women, ages 18 through 44, who had a preventive medical visit in the past year	RPMS	12.1	18.1	18.7	19.7	41.9	22.1	▲246.3
NPM 4 A	Percent of infants who are ever breastfed	HVSO	95.5	94.7	95.8	96.5	93.3	95.2	▼2.3
NPM 6	Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	CHCC Children's Clinic	4	10.2	12.1	33.4	20	15.9	▲400.0
NPM 9	Percent of adolescents, ages 12 through 17, who are bullied or who bully others	YRBSS	28.5	28.5	29.4	29.4	24.4	28.0	▼14.4
NPM 11 A	Percent of children with special health care needs, ages 0 through 17, who have a medical home	CSHCN Program	46.8	46.8	19.6	19.6	13.3	29.2	▼71.6
NPM 13.2	Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.	CHCC Dental	13.6	11.9	12.3	15.4	6.2	11.9	▼54.4

Note: Percent Change - calculates the difference between two data points (latest and begining) divided by the initial value (beginning) then multiply by 100 to represent percent.

Longitudinal study can provide a dynamic view of MCH population health status. Data collected from (2016 through 2020) for the MCH population shows increases in all six (6) National Outcome Measures; and 2 of 6 National Performance Measures. Data suggest that MCH made improvements on NOM 1, NPM 1, NPM 6, and NPM 9. It is important to recognize that data collected in the CNMI from 2016, and 2018, was influenced by two (2) super typhoons; and from December 2019 to present, by the COVID-19 pandemic.

Table 2: Trend Analysis of the Selected SPMs and ESMs from 2016 to 2020

CNMI MCH TREND ANALYSIS, 2016 to 2020									
STATE PERFORMANCE MEASURES (SPMs)		DATA SOURCE	2016	2017	2018	2019	2020	mean	Outcome / % change
SPM 1	Percent of women ages 15 thru 44 years screened for anemia with hemoglobin and hematocrit done in WCC, L&D and OB.	CHCC LABORATORY	70.4	66.4	66.9	59.1	59.5	63.0	▼10.4
SPM 2	Percent of deliveries to resident women who received prenatal care beginning in the first trimester of pregnancy.	HVSO	43.4	45.8	47.5	47.9	55	47.9	▲26.7
SPM 3	Percent of children ages 19 through 35 months who complete the combined 7-vaccine series (4:3:1:3:3:1:4)	WEBIZ	42.9	48.9	51.5	55.6	71.5	54.1	▲66.7
SPM 4	Percent of high school students enrolled in Public School System grades 9th through 12th who report thoughts of suicide on the YRBS.	YRBSS	22.8	25	25	28.5	28.5	26.0	▲25.0
SPM 5	Percent of births among resident teen ages 15 to 17 years	HVSO	11	8.4	10.8	11.8	7.8	10.0	▼29.1
SPM 6	Percent of children, ages 0 thru 17 years, seen at CHCC with continuous health insurance coverage.	RPMS	44.7	48.9	52	54.1	56	51.1	▲25.3
EVIDENCE-BASED OR INFORMED STRATEGY MEASURES (ESMs)		DATA SOURCE	2016	2017	2018	2019	2020	mean	Outcome / % change
ESM 1.1	Percent of women ages 18 thru 44 seen at mobile clinic outreach events.	MCH DATASET	2.9	1.6	3.3	1.9	0	1.7	▼34.5
ESM 1.2	Percent of women ages 18 thru 44 seen at the Family Planning Program.	FAMILY PLANNING DATASET	9.2	13.4	16.5	17.5	17.5	14.8	▲90.2
ESM 4.2	Percent of infants enrolled in Home Visiting breastfed through 6 months.	H.O.M.E Visiting Prog	51.6	56.5	45.1	49.1	70	54.5	▲35.7
ESM 6.1	Percent of children who complete an ASQ screening at the CHCC Children's Clinic during a well-child visit.	CSHCN ASQ DATASET	38.4	53.6	61.2	80.5	83.1	63.4	▲116.4
ESM 9.1	Percent of schools that have implemented evidence based programs to address bullying.	MCH DATASET	0	45	40	40	40	33.0	▼11.1
ESM 13.2.1	Percent of children from 2nd and 6th grade public elementary schools who receive dental sealants through the Public Health School Sealant Program.	CHCC DENTAL	56.3	55.6	61.8	70.2	41.9	57.2	▼25.6
Note: Percent Change - calculates the difference between two data points (latest and begining) divided by the initial value (beginning) then multiply by 100 to represent percent.									

Of the 6 State Performance Measures (SPMs) selected from the prior 5-year cycle, only SPM 1 was selected for continued reporting for years 2021-2025. Data collected illustrates improvements in state performance measures include: SPM 2, SPM3, SPM5, and SPM 6.

Six (6) Evidence-based or Informed Strategy Measures (ESMs) were developed by States to demonstrate its impact on NPMs as indicated in the State Action Plan. Based on the data collected from the previous 5-year cycle, 3 ESM (ESM 1.2, ESM 4.2 and ESM 6.1) shows improvement and quality performance related to selected NPMs; however, 3 ESM (ESM 1.1, ESM 1.9 and ESM 13.2.1) indicated decreasing trends in number of individuals served.

MCH Jurisdictional Survey

The first Maternal and Child Health Jurisdictional Survey (MCH Jurisdictional Survey) was administered from January 27, to February 5, 2020, by the National Opinion Research Center (NORC) at the University of Chicago, with its sub-contractor, Tebbutts Research. The purpose of the MCH Jurisdictional Survey was 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 identified tier 1 jurisdiction-specific priorities aimed at improving the health of MCH populations. The design of MCH Jurisdictional Survey was 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.
NORC was in-charge for administering the survey, which involved hiring and training enumerators and collecting, validating and analyzing data. A targeted sample size of about 200 respondents was determined to be sufficient size to reduce sampling errors or biases while using various statistical manipulations during data analysis. Enumerators were instructed to maintain confidentiality, implement quality control procedures, randomize, and perform in-person

interviews at the respondent's residence using paper and pencil interview (PAPI).

Respondents were asked to answer questions using structured and standardized questionnaires that were both quantitative and qualitative in nature. In all, 218 complete household interviews were conducted at 21 various geographic locations on the island of Saipan. 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 cautiously.

Approximately, 36%, (6 NOMs and 6 NPMs) of indicators from the 2020 MCH Jurisdictional Survey comprised of programmatic data collected from 2016 through 2020 for the MCH Title V Block Grant annual reports.

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

Other MCH data capacity efforts include the following:

- **Pregnancy Risk Assessment Surveillance Monitoring System (PRAMS)**: Commonwealth of the Northern Mariana Islands Pregnancy Risk Assessment Monitoring System (CNMI PRAMS) will be a joint research project between the Commonwealth Healthcare Corporation (CHCC) and the Centers for Disease Control and Prevention (CDC). The project involves the development and completion of a protocol and implementation of a population-based surveillance system designed to identify maternal attitudes and experiences before, during and after pregnancy. Research indicates that maternal behaviors during pregnancy impact infant birthweight, gestation and mortality rates. The CNMI PRAMS will strengthen capacity in the CNMI to produce high quality data not available from other sources relating to pregnancy and the first few months after birth and enable the monitoring of maternal and infant health indicators over time. The goal of CNMI PRAMS is to identify maternal risk behaviors that may affect both maternal and infant health. Findings from CNMI PRAMS will be used to enhance the understanding of maternal behaviors among the territory's diverse population and their relationship with adverse pregnancy outcomes. The CNMI CHCC will use PRAMS surveillance data for program planning and evaluation and influencing public health practice and policy for maternal and child health programs.
- **Carevue Electronic Health Record (EHR) System:** The CHCC, CNMI Health Department, is transitioning to a new EHR system. This upgrade is intended to improve the capturing and reporting of patient data and interoperability or linkages with other healthcare data systems. This project being spearheaded by the CHCC Health Information Technology (HIT) Department. The CHCC outpatient clinics serving women and children, emergency department, L&D, OB, Pediatrics, and other women and children serving hospital units will utilize this integrated health record system for capturing preventive, primary, and other patient care information.
- **Family Planning Annual Report (FPAR) 2.0:** The CNMI Family Planning program completed computer hardware upgrades for Family Planning providers at the CHCC Women's Clinic, Rota Health Center, and Tinian Health Center. Additionally, through a partnership with the CHCC HIT, the program is working with Carevue to ensure that all FPAR 2.0 data elements required by the Office of Population Affairs are included in the development and deployment of the new CHCC EHR system that is scheduled to launch in the fall of 2021.
- **Immunization System linkage to EHR- System Interoperability:** Through a partnership with the HIT Department, the Immunization Program is working on upgrades to the CNMI Immunization Information System (IIS) called the Webiz, to enable linkages between the hospital and clinics EHR and the IIS. This upgrade will improve the capturing and reporting of vaccination data in the CNMI and is estimated to be completed in the fall of 2021.
- **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 to link the database to live birth records captured in the newly implemented EVRS.

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

Recent natural disasters that impacted the CNMI in addition to the global COVID-19 Pandemic required the CNMI MCH system to shift attention towards emergency planning and preparedness for the CNMI MCH populations. In 2015 and then again in 2018, the CNMI experienced category five super typhoons which devastated the territory and caused significant destruction to infrastructure services. Just as the CNMI was beginning to recovery from the 2018 Super Typhoon Yutu, the global COVID-19 Pandemic was declared, causing much disruption throughout various service industries, public health, and government and non-government operations.

Currently, all CNMI Title V personnel are required to complete FEMA Incident Command Training as part of the CHCC's organizational training requirements. MICAH programs staff at all levels, depending on the size and scope of an emergency response, are involved in disaster response when needed. During the super typhoons in 2015 and 2018, MICAH programs staff were involved in planning, logistics, operations sections of the CHCC incident command structure and took part in activities that included health outreach at shelters, providing assistance with identifying MCH populations in need of medical care (prenatal care, vaccinations, oral health care, etc.), assisting with access to contraceptives, distributing infant safe sleep supplies and hygiene supplies (i.e. shampoo, infant diapers, toothbrush).

In 2020, MICAH programs completed Tropical Storm and Typhoon response protocols which identified communications channels and standardized response activities before, during, and after storms.

During COVID-19 pandemic response, Title V staff were once again involved in all areas of the incident command structure in addition to supporting communications, surveillance, and contract tracing activities. One of the advantages of the Title V program being situated within an integrated health system and within the MICAH unit is the opportunity to coordinate seamlessly across various MCH serving programs, such as WIC, Immunization, Home Visiting, Newborn Screening, and Family Planning, among others. These internal partnerships will be leveraged for identifying areas within the CNMI's Emergency Operations Plan that need to be updated to address the needs of the MCH populations.

The CNMI's Emergency Operations Plan (EOP) was last updated in January 2000. The CNMI Homeland Security and Emergency Management (HSEM) department is responsible for annual review and update of the CNMI EOP. According to the HSEM Lead Planner, the EOP will be updated in 2021. The CNMI Title V program works collaboratively with the CHCC Public Health Emergency Preparedness Program (PHEPP) in addressing the needs of women and children in responding to disasters and will work together in assessing areas within the current EOP that needs to be updated to reflect a focus on MCH needs before, during, and after disasters.

The PHEPP and MCH Title V program staff recently completed a disaster preparedness learning collaborative coordinated through the Association of Maternal and Child Health Programs (AMCHP) which resulted in the identification of MCH preparedness related priorities and activities to focus on as next steps for addressing MCH emergency planning and preparedness. Over the next few months in 2021, the Title V an PHEPP will focus on the following priorities and activities:

Strategy: Integrate MCH considerations into state/territory EPR Plan

Activities:

- During the next 12 months, the MCH Director and the Public Health Emergency Program (PHEP) directors will meet at least one time to discuss EPR needs related to maternal and infant health.
- An MCH staff member will annually update the list of local and state/territory MCH partners, stakeholders and/or social networks to ensure that the contact information is accurate.
- An MCH staff member will ensure that state/territory EPR guidance for sheltering and other mass care needs address maternal and infant populations and the specific needs such as supplies and instructions

for infant feeding and safe sleep.

- Annually the MCH program updates its roster of which MCH staff members are trained to assume leadership or other positions during a response if the hazard has a disproportionate effect on women of reproductive age and/or infants.
-

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

Activities

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

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

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

Over the past several years, shifts in CNMI policies and the health care environment have impacted the health system services and sustainability. The CHCC, which provides both clinical and public health services, was formed in 2011. This reorganization provided a unique opportunity for integrated services between clinical and public health services. However, in such a financially constrained environment - systematic, evidence based, and outcome driven change posed challenging across the CHCC. In 2019, the CHCC began the needed process of clinical integration, starting with an assessment of programs and services and resulting in the integration of public health programs and services within the existing CHCC outpatient clinics (Children's Clinic, Women's Clinic, and the Family Care Clinic). While many of the CNMI MCH Title V programs were implemented in partnership with CHCC providers (i.e. Centering Pregnancy, Family Planning, Developmental Screening, SBIRT, etc.), this provided an opportunity for the programs within the CHCC MICAH to evaluate current activities, identify areas to be strengthened and develop plans to meaningfully engage CHCC physicians and clinical workers across all aspects of the MCH programs.

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

In addition to working closely with CHCC clinic providers, the MCH program works closely with community based partners on a variety of projects. A significant role that MCH plays towards ensuring access to healthcare is by working towards reducing barriers to access to care. The inability to pay or lack of insurance is often cited as a major obstacle in seeking preventive healthcare. The MCH Program works with the CNMI Medicaid agency to offer expedited application processing for women and children in the CNMI and receives referrals of at risk women or children from partner agencies and medical providers.
The CNMI Title V program regularly collaborates with federal, state, and non-governmental agencies towards efforts to improve and ensure access to quality health care and needed services for the CNMI MCH population.

- Centers for Disease Control & Prevention (CDC)
    - Pregnancy Risk Assessment Monitoring System (PRAMS)
        - Development of the CNMI PRAMS Protocol for implementation
    - Program Operations and Assessment Branch
        - The CNMI receives on-going technical assistance on immunizations and vaccine storage and handling, vaccine coverage assessments, and Immunization Information System (IIS) maintenance.
- Association for Maternal & Child Health Programs (AMCHP)
    - Emergency Preparedness & Response Action Learning Collaborative
        - The CNMI joined a multidisciplinary team, participated in peer to peer sharing, received

information/guidance from national experts and individualized technical assistance, and completed an action plan for incorporating MCH into emergency preparedness and response efforts.

- National Center for Education in Maternal & Child Health, Georgetown University
  - The CNMI MCH team has collaborated with John Richards and his team from the National Center for Education in Maternal & Child Health on reviewing Evidence Based or Informed Strategy Measures (ESMs) for the CNMI. The work involved reviewing strategies and ESMs and identifying areas for potential adjustments and realignment.
- University of Guam (UOG)
  - As part of the CNMI's work to develop a PRAMS protocol for implementation, the CHCC is working on a partnership with the UOG for Institutional Review Board approval. A Reliance agreement for human subjects research is currently being developed for implementation as part of this project.
- IT&E Telecommunications
  - As part of the CNMI's efforts for reminder and recall notices for vaccinations and towards improving vaccination coverage rates for COVID-19 vaccines, partnership was made with the IT&E telecommunications company. IT&E is one of two local telecommunications vendors in the CNMI.
- Northern Marianas Housing Corporation (NMHC)
  - Through a partnership with the CNMI NMHC, the CHCC was able to procure a new state of the art mobile clinic. The mobile unit is currently being built based on specifications requested by the CHCC and is estimated to arrive on Saipan in the Spring of 2022. The mobile clinic will be used as an extension of the CHCC primary care clinics and will offer preventive visits and screenings, including oral health, to the various villages in the CNMI.
- CNMI Public School System
  - CHCC MICAH programs partner with the CNMI Public School System (PSS) to address a variety of child and adolescent health initiatives. The partnership activities include school based services to offer adolescent sexual and reproductive health services, vaccinations, early intervention services, and training or capacity building activities on child health related topics.

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. 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 million 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. 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.

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 rom $6.9 million to $63.1 million and its FY 2021 allotment from approximately $7.1 million to $62.3 million. Congress has not made any additional funding available to the CNMI after September 30, 2021, which means that beginning October 01, 2021, and future years, federal funds for the CNMI's Medicaid program will revert back to the capped amount set in statute (approximately $7.2 million for FY 2022).

Recently, the CNMI Medicaid program submitted the following State Plan Amendments:

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

Additional funding coupled with state plan amendments, such as Presumptive Eligibility has resulted in significant increases in Medicaid enrollment in the CNMI through FY 2020. In FY 2019, the CNMI had a little over 14,000 individuals enrolled in the Medicaid program. By the end of FY 2020, the CNMI had a total of 36,637 Medicaid program enrollees, which accounts for almost 70% of the CNMI's total population.

CNMI Medicaid Program Enrollment by month - 2020

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

Source: CNMI State Medicaid Agency

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.

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

State Action Plan Introduction

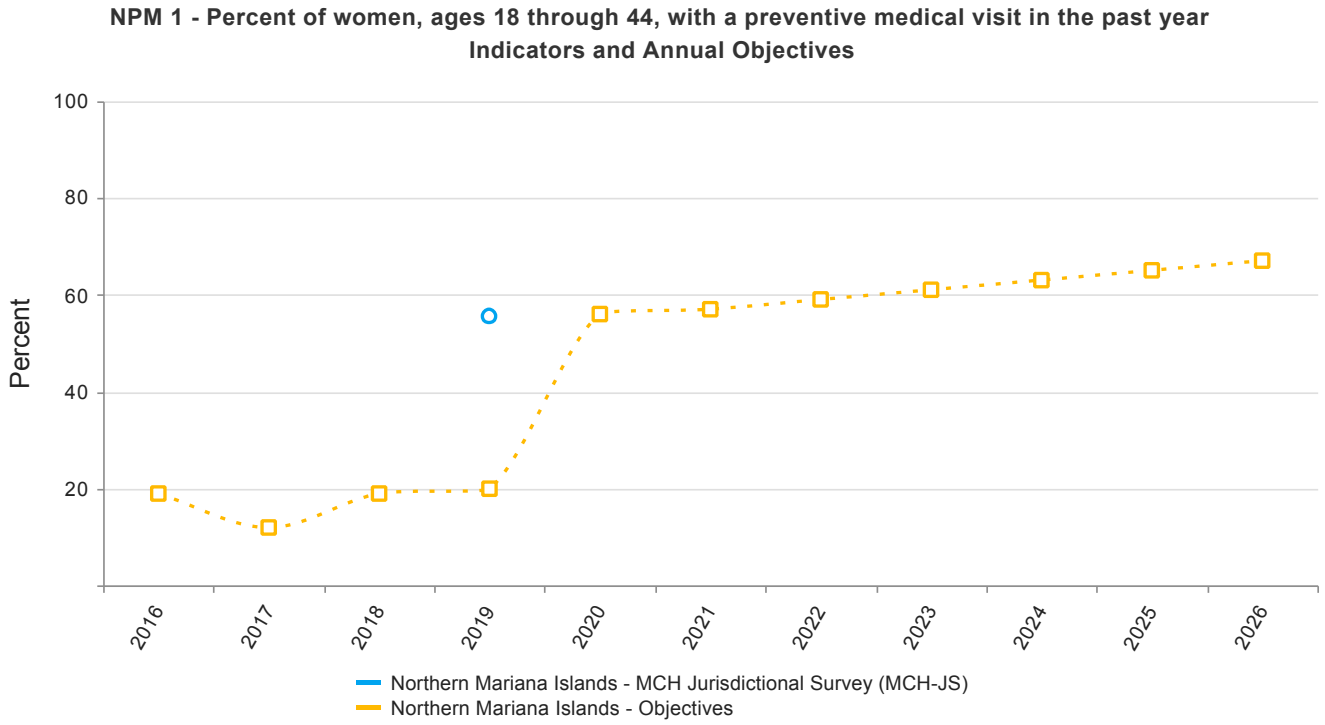
As part of the MCH Title V Program, the CNMI developed a five-year State Action Plan to address the priority needs for the CNMI's MCH population. The plan outlines both the planned activities for the upcoming year as well as activities that were completed in the reporting year, 2020. The CNMI's plan 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

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	MCH-JS-2019	10.8 %	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	7.1 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	MCH-JS-2019	14.2 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	8.7 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	28.0 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2019	14.5	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2019	Data Not Available or Not Reportable	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2019	Data Not Available or Not Reportable	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2019	Data Not Available or Not Reportable	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	20.6	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	MCH-JS-2019	56.5 %	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures



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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	19	12	19	20	56
Annual Indicator	12.1	18.1	18.7	19.7	41.9
Numerator	1,464	1,425	1,437	1,516	3,238
Denominator	12,096	7,863	7,690	7,689	7,721
Data Source	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CHCC Preventive Visits and US international census
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	57.0	59.0	61.0	63.0	65.0	67.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percentage of women who report an increase in access to preventive services.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Women/Maternal Health - Entry 1	
Priority Need	
Access to health services- ability to find and see a doctor when needed.	
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 by 10% from baseline.	
Strategies	
Expand preventive healthcare: Increase clinic hours	
Provide community awareness regarding women's preventive health services.	
ESMs	**Status**
ESM 1.1 - Percentage of women who report an increase in access to preventive services.	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

WOMEN/MATERNAL HEALTH

At the start of FY 2020, the CNMI was still in the process of recovery from massive destruction caused by the category 5 super typhoon Yutu. By the end of the first quarter, reports of a novel coronavirus had made its way to the CNMI and on January 29, 2020, the CNMI governor issued an executive order declaring a state of significant emergency regarding the novel coronavirus that ordered the Commonwealth Healthcare Corporation (CHCC) to implement quarantine and preventive containment measures. On March 16, 2020, Executive Order 2020-04, as amended, was issued declaring a State of Public Health Emergency and a continued Declaration of a State of Significant Emergency establishing response, quarantine, and preventive containment measures concerning COVID-19. This resulted in the CHCC establishing an agency emergency operations center and redirected all health department personnel to aid in the response to the novel coronavirus. In addition, and as result of the first cases of COVID-19 in the CNMI identified on March 28, 2020, subsequent executive orders were issued which implemented stay at home orders, curfews, and other restrictions to ensure the containment of COVID-19. Because of the fragile state of our territory health system, it was critical that preventive measures, including quarantine and other containment strategies, were implemented expeditiously to reduce the risk of potential major adverse impact. These measures resulted in modifications to healthcare services and for a temporary period required that preventive/primary care visits be offered via telehealth; program outreach activities were suspended for the remainder of FY2020.

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

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

In 2020, a total of 1,895 women completed a pap smear for cervical cancer screening. This is a 25 percent increase when compared to the total number of pap smears conducted in 2019 (n= 1,516) and a 31 percent increase compared to 2018 (n= 1,437).

While preventive visits and pap smears were temporarily suspended in the spring of 2020 due to the COVID-19 pandemic, services quickly resumed by the summer of 2020. Additionally, the CNMI State Medicaid Agency processed a State Plan Amendment in May of 2020 which allowed Presumptive Eligibility for Medicaid benefits, easing some restrictions around application processing and allowing the CHCC to make coverage determinations. This expanded coverage to many uninsured individuals in the community and increasing Medicaid coverage from 30 percent to 70 percent of the CNMI population. With the increase in healthcare coverage in the CNMI population the territory also saw major increases in preventive service utilization and had a positive impact on cervical cancer screening rates.

The MICAH unit via the SSDI Project, conducted a review of CHCC electronic health records for women ages 18 through 44 years seen at CHCC to identify the percentage of women accessing preventive health services via CHCC clinics. In 2020, 41.9 percent (n= 3,238) of women age 18 through 44 in the CNMI accessed preventive health services at CHCC. This percentage has been steady for the past 4 years and increased approximately 8 percent

since 2016.

Year	Numerator	Denominator	Percentage
2016	2753	8114	33.9
2017	3155	7895	40.0
2018	3214	7732	41.6
2019	3196	7742	41.3
2020	3238	7721	41.9

Source: CHCC RPMS

The limitation to this dataset is that the numbers are limited to women who accessed healthcare via the CHCC and does not reflect preventive services accessed through private clinic providers. It is important to note, however, that it is estimated approximately 80 percent of ambulatory care for the CNMI population is accessed via the CHCC. And while this data does not completely reflect the entire population, it does reflect a large proportion of healthcare accessed.

Strategy: *Utilize the clinic outreach events to bring preventive screenings and other health services into non-traditional sites and into under-served communities.*

The MCH program started the 2020FY with plans for monthly Women's Health outreach clinics. Through a partnership with CHCC programs such as the Breast and Cervical Cancer Screening Program (BCSP), STD/HIV screening and prevention program, and Immunization program, a total of 4 Women's Health outreach clinics were offered at a village location near the southern part of the island of Saipan. Services offered included breast and cervical cancer screening, basic prenatal care, HIV/STD screening, and Family Planning services.
Outreach events in 2020 were significantly impacted by the COVID-19 pandemic. In March of 2020, all outreach events were suspended as restriction of movement measures were implemented to contain the spread of the novel coronavirus within the CNMI. Women's health services continued to be offered at the CHCC Women's Health Clinic, Rota and Tinian Health Centers.

Strategy: *Promote Reproductive Life Planning and Preconception Care.*

Through partnership with the Family Planning program, reproductive life planning and preconception care is offered at all Family Planning service sites, including Women's Clinic, Rota Health Center, and Tinian Health Center. All patients seen through the Family Planning program develop a reproductive life plan as part of an annual visit. The program also offers preconception care for men and women of reproductive age. MCH works with Family Planning to advertise preconception care services via brochures, flyers, and radio advertisements.

Evidence Based Strategy Measure 1.2: Percent of women ages 18 thru 44 seen at the Family Planning Program.

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

In 2020, 15.1% (n= 1,164) of women ages 18 through 44 years in the CNMI accessed Family Planning services. This

is a 1 percentage point decrease from the previous reporting year. The slight decrease possibly due to the suspension of mobile clinic or outreach clinic events in addition to the impact the COVID-19 pandemic had on preventive healthcare seeking behavior among the CNMI population in 2020.

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State Performance Measure 1: Percent of women of childbearing age screened for anemia.

Year	2017	2018	2019	2020
% Screened	66.4	66.9	59.1	59.5
Numerator	1590	1656	1348	1151
Denominator	2395	2476	2279	1936

Source: CHCC RPMS

Numerator value represents total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery who were screened for anemia.
Denominator value represents the total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery.

The MCH Program and Needs Assessment Steering committee performed an assessment of State Performance Measure 1, Percent of Women of Childbearing Age with Anemia, to identify the impact and determine whether the measure reflected the intent of addressing the issue of anemia among the maternal population in the CNMI. During the 2015 MCH Needs Assessment, qualitative information gathered through the CHCC Ob/Gyn department identified an increase in the number of prenatal patients being diagnosed with anemia and that there was a need to increase anemia screening among the women/maternal population. As such, anemia was determined to be a priority area for addressing the health of women in the CNMI. The program and Needs Assessment Steering Committee, through guidance received from reviewers during the 2019 block grant review, have determined that instead of focusing on the rate of women diagnosed with anemia, the program will focus on increasing anemia screening rates. Therefore, SPM 1 was inactivated and an ESM was developed for reporting year 2019 to reflect efforts/strategy for anemia screening among the women/maternal population in the CNMI. The CNMI reviewed data on women seen through the CHCC health system. Denominator values obtained were the unduplicated number of women of reproductive age, 18 through 44 years, who were seen through the Women's Clinic, hospital Labor & Delivery, and Obstetrics unit. The numerator values are represented by the total unduplicated number of women of reproductive age, 18 through 44 years, who were seen by the CHCC Women's Clinic, Labor & Delivery and Obstetrics unit who were screened for anemia.

Strategy: Increase access to anemia screening.

The MCH strategy for increasing access to anemia screening was to include screening during outreach events. However, due to outreach events in 2020 being cancelled as a result of the COVID-19 pandemic, this activity was impacted. Alternatively, CHCC provides anemia screening for women seen through outpatient or inpatient services and the CNMI WIC program also offers anemia screening for enrolled female participants. The WIC program also experience significant impact to their program services due to the COVID-19 pandemic. All face-to-face visits with WIC participants were transitioned into telehealth visits resulting in anemia screenings being waived during the pandemic period. Nevertheless, the MCH program continues to conduct community awareness regarding the importance of early and adequate prenatal care and well woman preventive visits as a strategy for improving the number of women assessed and screening for anemia.

Women/Maternal Health

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 state. CHCC MICAH Programs have existing successful partnerships, resources and services and at an adequate position to provide more and engage community partners, build on existing programs, and address the needs of the state's woman/maternal population. The following actions are addressed in this priority: uniform screening, coordinated care, increased access to care through extended hours and additional locations, increased well woman visits, and understanding of preventive health coverage.

Activities to address priority areas identified during the 2020 comprehensive needs assessment for the Women/Maternal Health domain will continue to be guided by the life course framework. The priority selected for the next five-year cycle is focused on access to health services and the ability for women to find and see a doctor when needed. The MCH program will work in partnership with clinical providers and partners to ensure activities to address this priority are implemented on the islands of Saipan, Tinian, and Rota. Additionally, on Saipan, a new mobile clinic is currently being procured and expected to arrive to the CNMI in the Spring of 2022. MICAH programs will utilize the mobile clinic as part of an overall population health efforts, to expand access to preventive care and services for MCH populations.

The priority is linked to National Performance Measure 1, in which annual reporting on the percentage of women ages 18 through 44 years who access preventive medical visits will be conducted.

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

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.

The MCH program will focus on increasing clinic hours or adding additional service sites, including outreach or mobile clinics, as a mechanism for expanding access to preventive healthcare. For FY 2021, the following work plan outlines the approach and activities to be conducted:

Year 2: October 2021 – September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Meet with CHCC Chief of Clinics to discuss clinic hours and mobile clinic operations.	MICAH Administrator	Meeting Completed. Plan for expanded hours and/or service sites drafted and approved.	October 2021-December 2021
Conduct community awareness on expanded clinic hours or service sites	Communications & Marketing Specialist	Number of advertisements conducted.	January 2022-September 2022
Assess service utilization and impact due to increase hours and/or additional sites.	MCH Coordinator/SSDI Coordinator	Survey Developed	January 2022

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 Electronic Health Records (EHR). The program will assess the number and percentage increase in service utilization on a monthly basis among women/maternal population seen.

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 inform the community regarding available services, service sites, and hours.

Year 2: October 2021 – September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Conduct a survey or focus group to inform development of marketing and communications activities and materials	Communications & Marketing Specialist/Family Planning Coordinator	Data collection conducted and report prepared	September 2021- January 2022
Develop Women's Health community awareness campaign plan to include a plan for evaluation of activities	Communications & Marketing Specialist/ SSDI Project Coordinator	Women's health community awareness plan developed.	February 2022
Print materials	MICAH Administrative Assistant	Materials Printed & Disseminated	March 2022
Conduct presentations to program partners	Communications & Marketing Specialist/MICAH Administrator	Number of presentations conducted Number of participants	April 2022 – September 2022

Perinatal/Infant Health

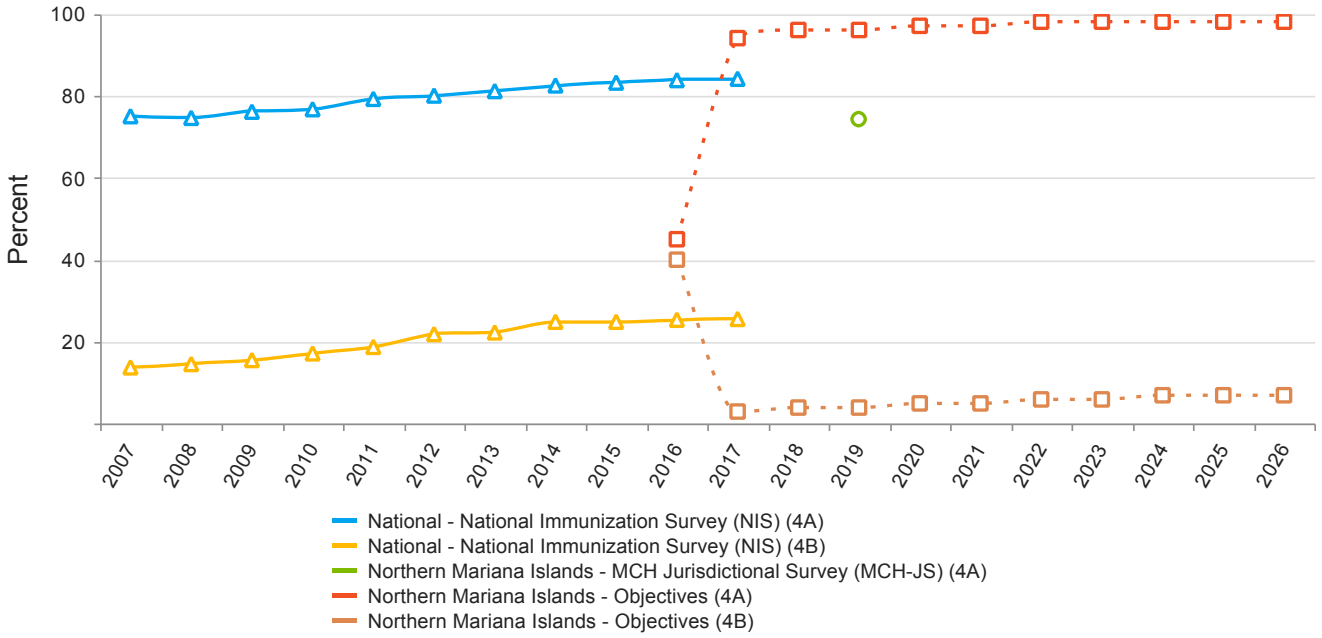
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2019	Data Not Available or Not Reportable	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2019	Data Not Available or Not Reportable	NPM 4
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2019	Data Not Available or Not Reportable	NPM 4

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**
Annual Objective	96	97
Annual Indicator	74.2	74.2
Numerator	4,288	4,288
Denominator	5,776	5,776
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	45	94	96	96	97
Annual Indicator	95.5	94.7	95.8	96.5	93.3
Numerator	1,162	1,145	1,209	877	610
Denominator	1,217	1,209	1,262	909	654
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	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	97.0	98.0	98.0	98.0	98.0	98.0

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

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	40	3	4	4	5
Annual Indicator	1.7	2.5	2.5	1.1	0.4
Numerator	9	13	12	5	2
Denominator	535	518	486	470	544
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	6.0	6.0	7.0	7.0	7.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percentage of workplace presentation participants who report increase in knowledge and skills regarding workplace breastfeeding policies.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

State Performance Measures

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		45	47	49	51
Annual Indicator	43.4	45.8	47.5	47.9	55
Numerator	319	297	323	334	347
Denominator	735	648	680	697	631
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	53.0	55.0	55.0	60.0	60.0	60.0

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 number of infants breastfeed through 6 months by 10% from baseline.	
Strategies	
Develop or strengthen prenatal clinic policies on breastfeeding education and counseling.	
Implement workplace breastfeeding policies/support	
ESMs	**Status**
ESM 4.1 - Percentage of workplace presentation participants who report increase in knowledge and skills regarding workplace breastfeeding policies.	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 deliveries to resident women receiving prenatal care beginning in the first trimester of pregnancy.

Objectives

By 2025, increase the number of pregnant women with first trimester prenatal care by 10% from baseline.

Strategies

Provide service navigation for prenatal women

PERINATAL/INFANT HEALTH

The CNMI MCH Program's priorities around perinatal/infant focus on improving breastfeeding rates and rates of early initiation of prenatal care among pregnant women. Prenatal care is most effective when it starts early and continues throughout pregnancy. It can help prevent and address health problems in both mothers and babies. In the CNMI, only 55 percent (n=347) of non-tourist live births are to mothers who initiated prenatal care during the first trimester of pregnancy. This figure is a 10% increase from the 2016 CNMI data, however, still trails behind the US national percentage of 77.6 percent of live births to mother with early prenatal care.

In FY2020, the CNMI was still in the process of recovery from catastrophic damages that resulted from the Super Typhoon Yutu that happened in the year prior. Outreach activities in FY2020 were cancelled due to the COVID-19 pandemic and efforts across the CHCC/CNMI health department were prioritized towards responding to the public health emergency.

National Performance Measure 4A: Percent of infants ever breastfed.

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

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 2020, 93.3 percent (n= 610) of infants born were breastfed. There was slight decrease from 96.5 (n= 877) percent from the year prior in the percentage of infants ever breastfed. A collaboration between the CNMI MCH Program, WIC, and the CHCC Hospital, which is the only birthing facility in the CNMI, has been a critical component for

Maternal & Child Health (MCH) Jurisdictional Survey Data

In 2020 the MCH Jurisdictional Survey was conducted in the CNMI. Data gathered from the survey indicated that **74.2 percent of infants in the CNMI were ever breastfed.**

ensuring breastfeeding initiation remains high.

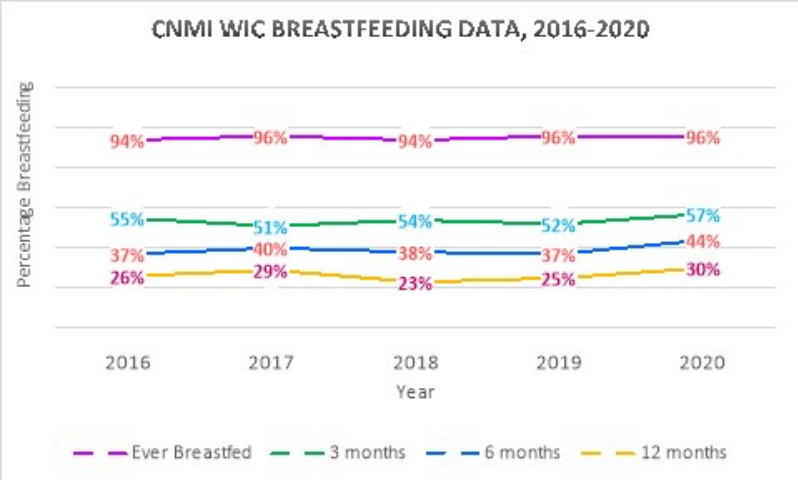
National Performance Measure 4B: Percent of infants breastfed exclusively through 6 months.

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

Source: CNMI WIC Program

For NPM4B: Percent of infants breastfed exclusively through 6 months, the MCH program utilizes WIC breastfeeding data to report on this measure as a proxy measure for CNMI rates. In 2020, a less than half one percent (n= 2) of infants was breastfed exclusively through 6 months of age. This is a decrease compared to the year prior, which was 1.1 percent (n= 5).

Breastfeeding Rates among CNMI WIC infants, 2019



Source: CNMI WIC Program

While breastfeeding initiation rates in the CNMI of 93.3 percent (n= 610) is higher than US national rate of 84.1 percent[i] , its 6 months breastfeeding rate (44 percent) trails behind the US average of 58.3 percent. A review of data on CNMI infants breastfed indicates that 57 percent of infants are breastfed at 3 months, 44 percent at 6 months of age, and 30 percent at 12 months. Data illustrated in the graph above indicates increases in breastfeeding rates at 3, 6, and 12 months compared to the year prior, 2019; an upward trend that the MCH program and WIC program are working collaboratively to maintain.

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 50 percent are being breastfed by 3 months of age and by 6 months, 44 percent are breastfed.
Many factors contribute to success in continued breastfeeding and support to breastfeeding moms is critical. Having to return to work is one factor and women typically return to work before a baby is 3 months of age. In the CNMI, the average maternity leave time is 15 business days for a government employee. Additionally, little is known about the types and level of breastfeeding support provided by local employers, both in the government and private sectors. Lactation support outside of the typical work week is also lacking in the CNMI. The WIC program is the only program in the CNMI that provides peer counseling services dedicated to supporting moms in breastfeeding. Unfortunately, peer breastfeeding counseling services are not available before 7:30am, after 4:30 pm, and on weekends. Additionally, the COVID-19 pandemic impacted peer counselor support that is made available at the CHCC Obstetrics unit with morning peer counselor rounds temporarily suspended in FY2020.

Strategy: Increase access to breastfeeding support and education.
The MCH program continues its partnership with the hospital nursery, NICU, and pediatrics units in supporting the breastfeeding needs of babies and their families who access hospital services. Breast pumps and breast pump kits available in these units are supported by Title V funds. Additionally, the MCH program partnered with CHCC Children's Clinic Provider, Dr. Heather Brooke to enhance lactation support services offered through the CHCC outpatient clinics. Dr. Heather Brooke is a certified IBCLC and began providing lactation consultation visits for women who needed additional support or experiencing challenges with breastfeeding. Additionally, Dr. Brooke facilitated capacity building training events focused on lactation and breastfeeding support, including: 4 hour CEU nurse training for CHCC NICU, L&D, Obstetrics, and Pediatrics hospital unit staff, 1 hour CEU for Children's Clinic nursing staff, and 2 grand rounds presentations for CHCC medical providers. Through Title V funds, lactation supports such as nipple creams, nipple shields, loaner breast pumps, and breast pump kits are made available to women who are seen at the Children's Clinic for lactation visits.

Strategy: Increase partnerships and collaboration in support of breastfeeding.
In 2020, the MCH program had plans to conduct training on employer support for breastfeeding and to partner with businesses to implement a pilot workplace breastfeeding project. However, due to the COVID-19 pandemic, plans were suspended and reprioritized for the next fiscal year.
The MCH program continued to work with the Home Visiting program to ensure breastfeeding support is provided to enrolled women. The MCH program facilitates referral of prenatal women to the Home Visiting program. Home Visitors (Family Partner Advocate) have completed training on lactation and breastfeeding support and the program offers breastfeeding supplies and breast pumps, for those who may need them or women returning to work.

Evidence Based Strategy Measure 4.2 Percent of infants enrolled in Home Visiting that are breastfed through 6 months.

Home Visiting	2016	2017	2018	2019	2020
Percent of Infants	51.6	56.5	45.1	49.1	70.0
Numerator	33	13	23	27	28
Denominator	64	23	51	55	40

In 2020, 70 percent (n= 28) of 6-month-old infants enrolled in the Home Visiting program were breastfed through 6 months of age. This is a 21 percent increase from the year prior.

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

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

In 2020, 55 percent (n= 347) of non-tourist live births were to women who accessed early prenatal care. Data for this measure is obtained through the Birth Registry from the CNMI Health and Vital Statistics Office. There was a 7 percent increase in the percentage of early prenatal care compared to the prior year.

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

As part of efforts to increase community awareness regarding the importance of early and adequate prenatal care, the MCH program developed posters and an updated prenatal care awareness video for distribution within the CNMI community. Posters were displayed at the Food Stamp Office, Medicaid Office, and the Tinian Health Center and Rota Health Centers.

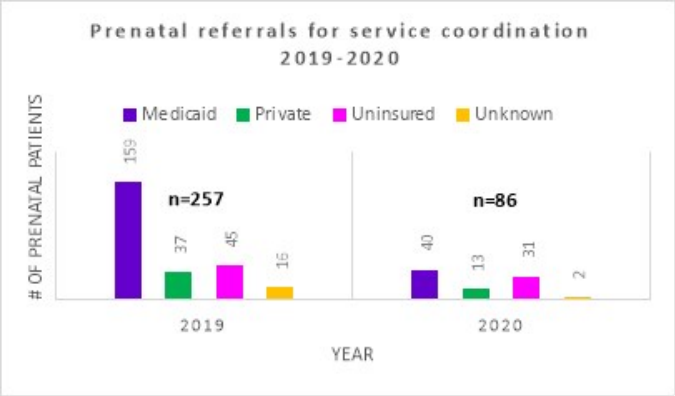
The MCH program had updated its prenatal care awareness video and had plans to air the videos at the local movie theater on the island of Saipan. However, due to the COVID-19 pandemic, the movie theater was shut down and the contract for airing the MCH videos was cancelled.

Strategy: Increase access to prenatal care

In 2020, the MICAH unit began offering transportation vouchers for free transportation to healthcare services for pregnant women. Informational advertisements and flyers were disseminated throughout partner programs and placed in the local newspapers.

In 2019, the MCH program worked with the Family Planning Program to develop and begin utilizing a referral protocol for prenatal patients. Through Title V funds, free pregnancy testing is made available at the CHCC Women's Clinic for patients seen through Family Planning. Patients who are identified pregnant are referred to the MCH program for prenatal service coordination where an assessment for risk status is completed and assistance in

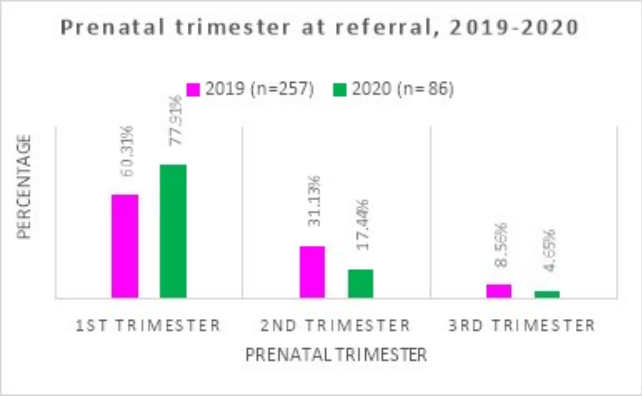
accessing supports and services, including Medicaid application processing, prenatal transportation assistance, and referrals to other programs such as tobacco cessation is provided. A standard operating procedure (SOP) outlining prenatal service coordination was developed.



Prenatal Referral to MCH Program by insurance status, 2019-2020

A total of 86 pregnant women were referred to the MCH program for prenatal service coordination. This total number was a decrease from the 257 prenatal referrals received the year prior in 2020. Of the Total referrals in 2020, almost half (46%) were women enrolled in Medicaid and more than one-third (36%) were uninsured. The decreases in referral and prenatal service coordination activity in 2020 was a result of the CHCC's efforts to respond to the COVID-19 pandemic. The MCH program staff were activated as part of the CHCC emergency operations center and stationed in areas to support response to COVID-19. The MCH services coordinator, who is the lead in providing prenatal service coordination, was assigned to support the COVID-19 response communications section.

Graph 6. Prenatal referrals to MCH Program by trimester, 2019-2020



A review of the past two years of prenatal referrals illustrates that program received higher percentage of early (first trimester) referrals in 2020 compared to 2019. Although the overall referral number in 2020 decreased, larger percentage of the 2020 referrals (78%) were of women in their early stages of pregnancy compared to 60% in 2019.

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

Perinatal/Infant Health

MCHB 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 successes of 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. These priorities reflect the MCH program's focus to current work by addressing the clinic processes as the best way to reach positive outcomes. The following actions are addressed in this priority: uniform screening, coordinated care, and exploring options for increased access to care through extended hours and additional locations, increased prenatal visits, and access to transportation. Taken together, these needs can be addressed through existing programs as well as new initiatives and contribute to the whole health of the child beginning prenatally and throughout the life course.

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 number of infants breastfed through 6 months to 54%, an increase of 10% from baseline.

Strategy: Implement workplace breastfeeding policies/support

In FY 20201, due to the COVID-19 pandemic, the MCH program was not able to conduct activities around workplace breastfeeding policies and support. This activity will continue into FY 2022.

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

Year 2 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.

Year 2: October 2021 – September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Develop a survey to assess workplace breastfeeding support/policies	SSDI Project Coordinator	Survey Instrument Developed	October 2021-January 2022
Conduct Survey	SSDI Project Coordinator/MCH Coordinator	Number of surveys completed	February 2022-April 2022
Conduct analysis to determine baseline number and types of workplace policies exist in the CNMI	SSDI Project Coordinator/MCH Coordinator	Survey Results Finalized and Disseminated	May 2022- June 2022
Identify workplace/agencies to initiate technical assistance for establishing workplace policies on breastfeeding	MCH Coordinator	-Agencies/worksites identified -Meeting Conducted to introduce the project	July 2022-September 2022

Evidence Based Strategy Measure (ESM) 4.1: Complete workplace lactation support assessment to determine percentage of CNMI employers who provide support or have existing organizational policies for supporting employees with breastfeeding.

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

SPM 1: Percent of prenatal women with first trimester prenatal care.

Objective: By 2025, increase the number of pregnant women with first trimester prenatal Care to 65%, an increase of 10% from baseline.

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.

Year 1: October 2021 – September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Establish call center services for Prenatal women to access information and services	MCH Services Coordinator	Call Center services contract established	October 2021-December 2021
Promote Prenatal call center information	Communications & Marketing Specialist	Number of advertisements/social media posts & numbers reached	January 2022-September 2022
Partner with Family Planning program to promote free pregnancy testing	MCH Services Coordinator/ Family Planning Coordinator	Number of women seen for pregnancy testing Number of women referred to MCH by Family Planning	November 2021-September 2022
Provide Service navigation at risk prenatal patients	MCH Services Coordinator	Number of prenatal patients enrolled in Service Navigation	October 2021-September 2022

Child Health

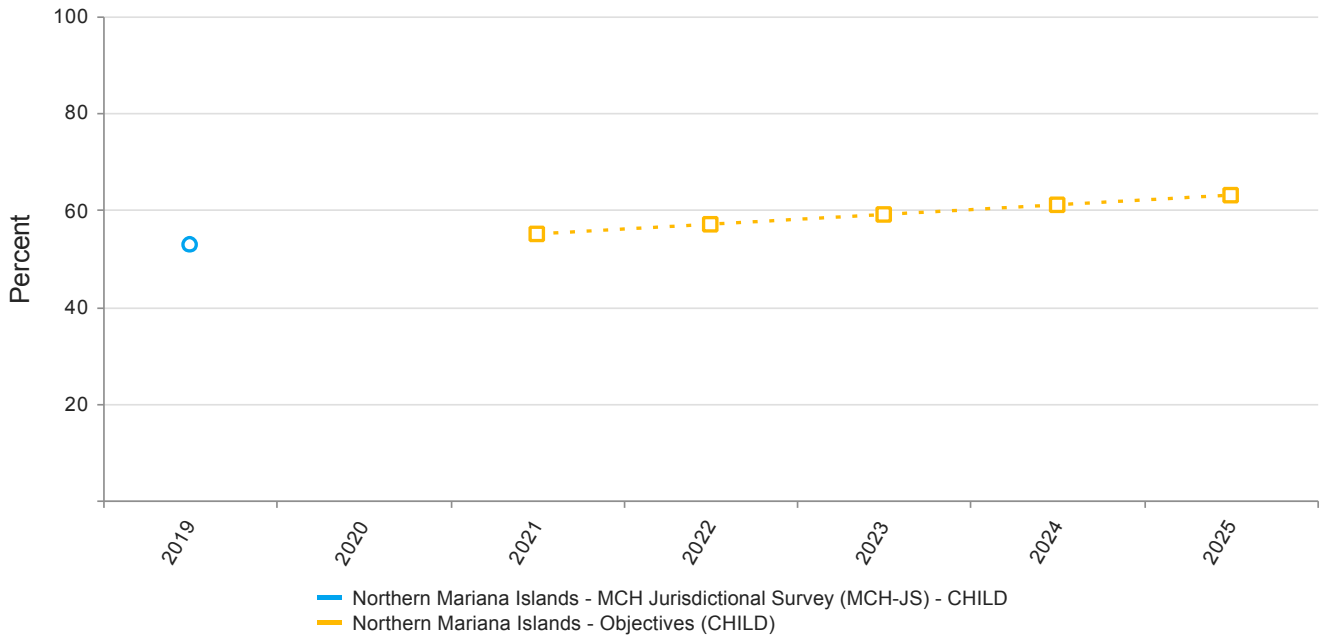
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	MCH-JS-2019	13.0 %	NPM 13.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	2.6 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	81.2 %	NPM 6 NPM 8.1 NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 6 NPM 8.1 NPM 13.2
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)	MCH-JS-Age 0-2	Data Not Available or Not Reportable	NPM 8.1
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)	MCH-JS-Age 10-17-2019	17.5 %	NPM 8.1
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)	NSCH	Data Not Available or Not Reportable	NPM 8.1
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)	WIC-2018	8.7 %	NPM 8.1
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)	YRBSS-2019	21.6 %	NPM 8.1

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**
Annual Objective		
Annual Indicator	52.7	52.7
Numerator	2,769	2,769
Denominator	5,253	5,253
Data Source	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	55.0	57.0	59.0	61.0	63.0	65.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Percentage of 6- 11 year old children accessing well-child visits who report being physically active at least 60 minutes per day.

Measure Status:	Active

Baseline data was not available/provided.

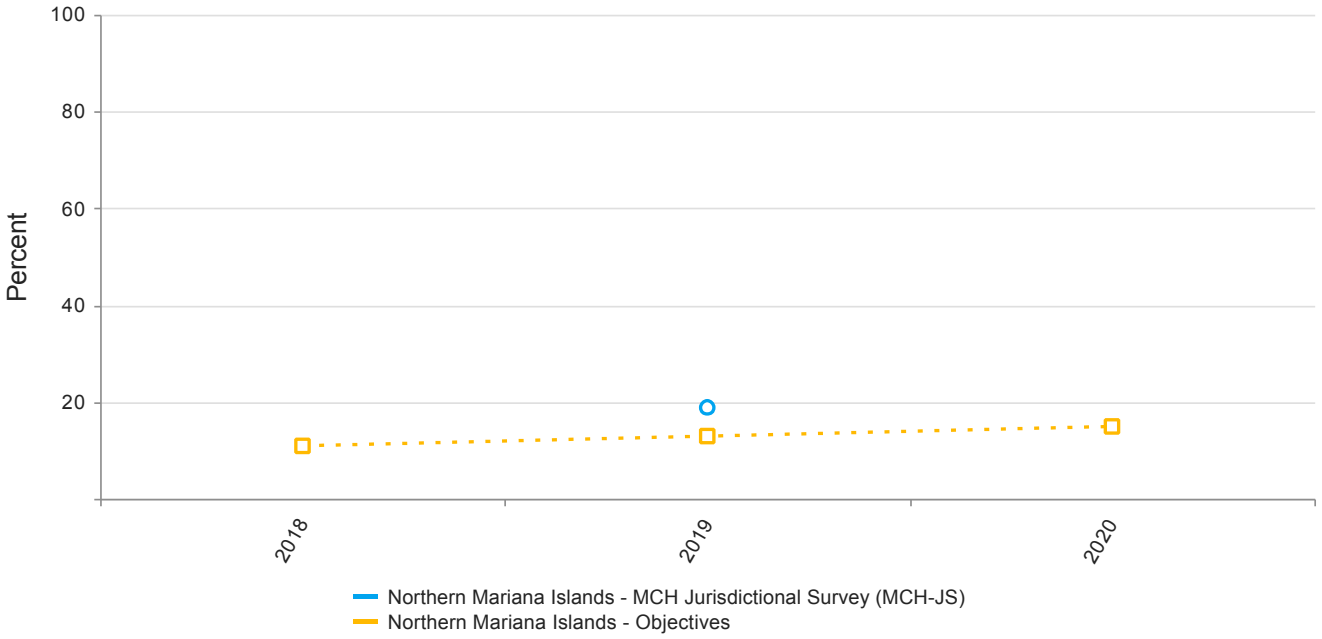
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

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 number of children ages 6 through 11 years who report being active at least 60 minutes a day by 10% from baseline.	
Strategies	
Increase the number of children accessing well-child visits.	
Increase community awareness regarding the importance of physical activity for children.	
ESMs	**Status**
ESM 8.1.1 - Percentage of 6- 11 year old children accessing well-child visits who report being physically active at least 60 minutes per day.	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)	

2016-2020: National Performance Measures

2016-2020: NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	13	15
Annual Indicator	18.8	18.8
Numerator	490	490
Denominator	2,609	2,609
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

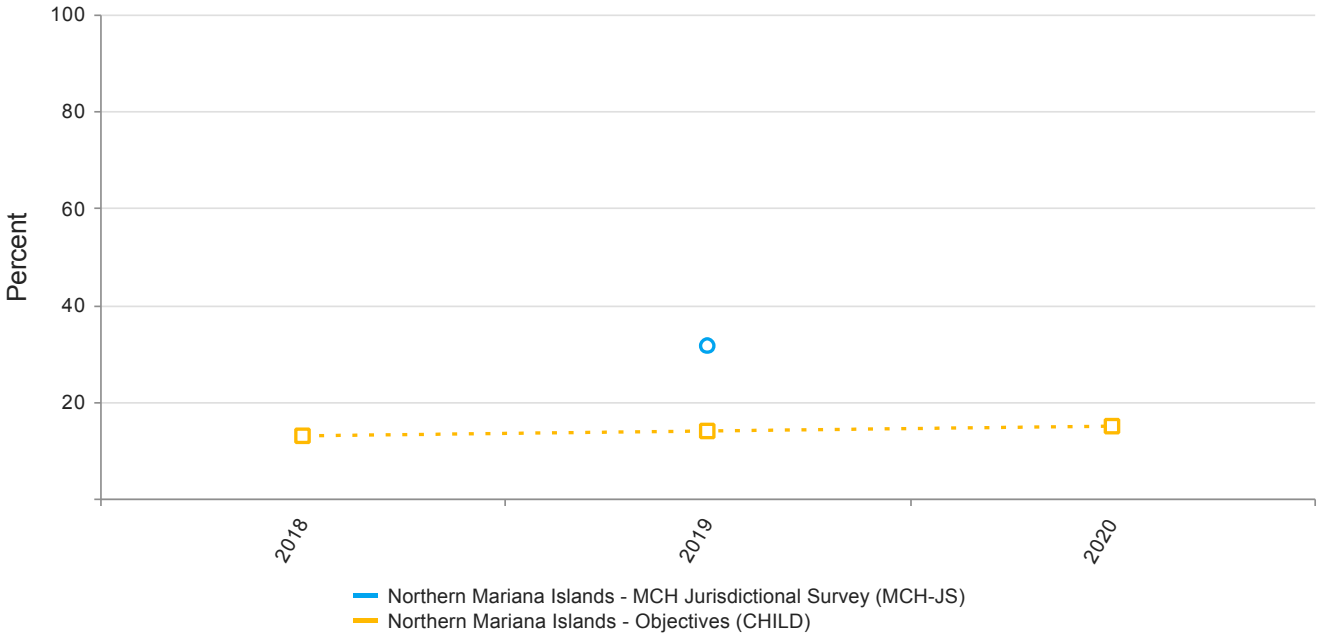
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			11	13	15
Annual Indicator	4	10.2	12.1	33.4	20
Numerator	103	215	321	694	489
Denominator	2,602	2,112	2,656	2,077	2,441
Data Source	Childrens Clinic Log/ US International Census	CHCC Childrens Clinic /US International Census	CHCC Childrens Clinic /US International Census	CHCC Childrens Clinic /US International Census	CHCC Childrens Clinic /US International Census
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 6.1 - Percent of children who complete an ASQ screening at the CHCC Children's Clinic during a well-child visit.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		40	55	63	65
Annual Indicator	38.4	53.6	61.2	80.5	83.1
Numerator	103	112	170	572	798
Denominator	268	209	278	711	960
Data Source	CHCC RPMS and Childrens Clinic ASQ screening log	CHCC RPMS and Childrens Clinic Log	CHCC RPMS and Childrens Clinic Log	CHCC RPMS and Childrens Clinic Log	CHCC RPMS and Childrens Clinic Log
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Indicators and Annual Objectives



2016-2020: NPM 13.2 - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	14	15
Annual Indicator	31.5	31.5
Numerator	5,221	5,221
Denominator	16,554	16,554
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			13	14	15
Annual Indicator	13.6	11.9	12.3	15.4	6.2
Numerator	2,025	1,900	1,934	2,359	937
Denominator	14,847	16,010	15,719	15,281	15,009
Data Source	CHCC Dental Clinic / US International Census	CHCC Dental Clinic / US International Census	CHCC Dental Clinic / US International Census	CHCC Dental Clinic / US International Census	CHCC Dental Clinic / US International Census
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 13.2.1 - Percent of children from public elementary schools who receive dental sealants through the Public Health School Sealant Program.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		15	16	65	70
Annual Indicator	56.3	55.6	61.8	70.2	25.4
Numerator	814	813	910	987	355
Denominator	1,446	1,463	1,472	1,406	1,399
Data Source	Public Health Dental Clinic/Oral Health Prg	Public Health Dental Clinic/Oral Health Prg	Public Health Dental Clinic/Oral Health Prg	CHCC Dental Clinic/Oral Health Prg	CHCC Dental Clinic/Oral Health Prg
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: State Performance Measures

2016-2020: SPM 3 - Percent of children receiving routine vaccines.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		68	50	52	54
Annual Indicator	42.9	48.9	51.5	55.6	71.5
Numerator	949	1,092	1,157	1,178	1,146
Denominator	2,214	2,232	2,247	2,120	1,603
Data Source	CNMI Immunization Program WEBiz	CNMI Immunization Program WebIz	CNMI Immunization Program WebIz	CNMI Immunization Program WebIz	CNMI Immunization Program WebIz
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: SPM 6 - Percent of resident children, ages 0 thru 17 years, seen at any CHCC site with health insurance coverage.

Measure Status:				Active
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			59	61
Annual Indicator	48.9	52	54.1	56
Numerator	7,350	6,892	6,642	5,745
Denominator	15,019	13,255	12,266	10,268
Data Source	CHCC RPMS	CHCC RPMS	CHCC RPMS	CHCC RPMS
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

CHILD HEALTH

The MCH program continued its focus on improving the rate of children that are completing developmental screening. Developmental screening is part of well child visits offered through the CHCC Children's Clinic and also is administered in Home Visiting, Head Start, child care centers, and the Early Intervention Program. Priorities for 2020 also included increase the number of children accessing preventive oral health care and routine vaccinations. On-time vaccination helps provide immunity before children are exposed to potentially life-threatening diseases. As one of the greatest achievements in public health, vaccinations has had the greatest impact on the reduction of the burden from infectious diseases and associated mortality, especially in children. It is estimated that, each year worldwide, vaccines prevent up to 3 million deaths.

Child health activities were impacted by the COVID-19 pandemic. Outreach, trainings, and other events were put on hold as the CHCC initiated an organizational response to focus on addressing COVID-19 in the CNMI.

National Performance Measure 6: Percent of children ages 9 months through 35 months who received a developmental screening using a parent completed screening tool in the past year.

ASQ Data	2016	2017	2018	2019	2020
Percentage of Children	1.8	10.2	12.1	33.4	20
Numerator	103	215	321	694	489
Denominator	2,602	2,112	2,656	2,077	2,441

Maternal & Child Health (MCH) Jurisdictional Survey Data

In 2020 the MCH Jurisdictional Survey was conducted in the CNMI. Data gathered from the survey indicated that **18.8 percent of children ages 9 months through 35** months received a developmental screening using a parent completed screening tool in the past year.

The percent of children, ages 9 through 35 months who received a developmental screening using a parent-completed screening tool in 2020 was 20 percent (n=489). Out of 2,441 children ages 9 through 35 months in the CNMI, 489 were reported to have been screened through the Ages and Stages Questionnaire: 3rd edition. The denominator value of 2,441 is based on population estimates in the CNMI provided by the US Census Bureau. Change in both numerator and denominator value is seen for 2020. The denominator value for 2020 has increased from 2,077, while the numerator value has decreased from 694 both compared to the previous year. The number of children screened is based on the unduplicated number of children screened through the CHCC Children's Clinic, with data maintained through the MCH program.

There are other programs in the CNMI that utilize the ASQ screening tool such as the Early Head Start and Head Start programs and daycare centers that receive Child Care Development Fund (CCDF) subsidies. Obtaining screening data has been a continuous challenge due to lack of a central data collection mechanism. Therefore, there is a great probability that the number of children being screened Is underreported in this measure as children screened outside of the CHCC Children's Clinic are not represented in this figure.

Strategy: Implement a data system to able to capture developmental screening results, monitor screening rates, and manage referrals to needed services.

The MCH program had anticipated to work on the development of a data system to serve as a central repository for developmental screening data as the CHCC's current electronic health record system but was not capable of supporting the needs. However, in 2019 the CHCC began the process of a transition from its current electronic health records system to the Carevue EHR, supported through an agency named Medsphere. The initial stages of the transition included completing an assessment to support the development of specific modules needed to address the CHCC's needs, including a central repository for developmental screening data. The estimated "go live" date for the Carevue EHR is January 2021. This activity has been delayed due to the COVID-19. New projected date is October 2021.

Strategy: Increase the number of clinics and early care and education settings that utilize the ASQs.

The MCH program has collaborated with the Child Care Development Fund to provide the Ages and Stages Questionnaire: 3rd edition training to CCDF subsidized daycare providers and staffs. A total of 51 participants received training to be able to conduct ASQ developmental screening at their daycare centers. In addition, program was successful with discussing opportunities in expanding developmental screening efforts with one of the private clinics. However, implementation was postponed due to priorities focusing on the COVID-19 public health emergency for both program and the clinic.

Strategy: Promote awareness of the importance of developmental screening and monitoring.

MCH program continues to promote awareness of developmental screening and monitoring by making the CDC Milestone Moments Booklets available in Newborn Packets that are distributed to all women prior to discharge from delivery. Educational handouts have been developed to educate parents of the importance of screening and to help parent's understanding on completing the parent-completed questionnaires. Monitoring cards have also been developed for and are provided to parents to record their children's screening results and to help parents keep track of when the next screening should be conducted. In addition, the MCH program coordinated with one of the Children's Clinic providers who conducted a presentation on Well Child Visit including the importance of developmental screening and monitoring through the Family-to-Family Health Information Center. After the presentation, families had chance to ask questions and discuss concerns with the provider. There was a total of 42 participants.

Evidence Based Strategy Measure 6: Percent of children that completed an ASQ screening at the CHCC Children's Clinic during a well-child visit.

ASQ Data	2016	2017	2018	2019	2020
Percentage of Children	38.4	53.6	61.2	80.5	83.1
Numerator	103	112	170	572	798
Denominator	268	209	278	711	960

Data gathered in 2020 shows that 960 children ages 6 months thru 36 months were seen at the Children's Clinic for a Well Child visit, and of those 798 children completed an ASQ developmental screening. A 2.6 percent increase is illustrated compared to the previous year despite the restrictions and families having fear of visiting the clinic due to COVID-19.

Title V funds are used to support the purchase of ASQ screening materials, resources, and toolkits. Resources such as activity sheets are printed out and provided to families to help guide parents in providing support to their children. In addition, age-appropriate books are provided at the Children's Clinic for children completing developmental screening during a well child visit. The MCH Program also provides technical assistance to the Clinic, monitoring developmental screenings and communicating areas that may need improvement.

Additionally, the MICAH unit has stationed a Program Assistant at the Children's Clinic who provides one on one assistance to parents who may need support in completing the ASQ tool. Primarily, the Program Assistant sees a majority of parents who bring their children in for the 6-month well-child check as this is the age in which the ASQs are initiated for children seen at CHCC.

National Performance Measure 13.2: Percent of children ages 1 through 17 years who had a preventive dental visit in the past year.

Dental Visit	2016	2017	2018	2019	2020
Percentage of Children	13.6	11.9	12.3	15.4	6.2
Numerator	2,065	1,900	1,934	2,359	937
Denominator	14,847	16,010	15,719	15,281	15,009

Maternal & Child Health (MCH) Jurisdictional Survey Data

In 2020 the MCH Jurisdictional Survey was conducted in the CNMI. Data gathered from the survey indicated that **31.5** percent of children ages 1 through 17 years had a preventive dental visit in the past year.

The MCH program collects data from the CHCC Oral Health Program to report on NPM 13.2: Percent of children

ages 1 through 17 years who had a preventive dental visit in the past year. In 2020, 6.2 (n= 937) percent of children ages 1 through 17 years accessed preventive oral health care through the CHCC dental clinic. It is important to note that the data is limited to children seen at the CHCC Oral Health Clinic and does not include information on children who accessed preventive dental care through private dental clinics on the island of Saipan. The COVID-19 pandemic and the declaration of the Public Health Emergency in the CNMI significantly impacted dental services offered via the CHCC Oral Health Clinic as well as services provided by the program via outreach (Head Start Fluoride Varnish and School Sealant programs).

Strategy: Increase access to preventive oral healthcare.

Prior to the declaration of public health emergency in the CNMI, the MCH program worked with the CHCC Oral Health Clinic to develop awareness videos that were aired at the local movie theaters during national pediatric dental month in February of 2020. The video promoted preventive oral health care including brushing, avoiding sugar sweetened beverages, and routine preventive dental visits.

The CHCC Oral Health Clinic works closely with the Public School System to provide school-based preventive dental services, namely the School Sealant Program. However, due to the COVID-19 pandemic, dental services were temporarily suspended and schools transitioned to online learning, resulting in school based oral health services being suspended. School sealants are typically provided to public school system students enrolled in the 2nd and 5th grades on the islands of Saipan, Tinian, and Rota.

The CHCC Oral Health program did resume operations after the temporary closure, prioritizing emergency dental needs and then opening up to routine services.

Evidence Based Strategy Measure 13.2.1: Percent of 2nd and 6th grade students from public schools who receive dental sealants.

Dental Data	2016	2017	2018	2019	2020
Percentage of Children	56.3	55.6	61.8	70.2	25.4
Numerator	814	813	910	987	355
Denominator	1,446	1,463	1,472	1,406	1,399

In 2020, there were a total of 1,399 2nd and 6th grade students enrolled in the Public School System. Of the total, 355 students received dental sealants through the CHCC Dental Clinic School Sealant Program. The data illustrates a 64 percent percent decrease and largely a result of the COVID-19 pandemic.

State Performance Measure 3: Percent of children receiving routine vaccines

Vaccines	2016	2017	2018	2019	2020
Percentage of Children	42.9	48.9	51.5	55.6	71.5
Numerator	949	1,092	1,157	1,178	1,146
Denominator	2,214	2,232	2,247	2,120	1,630

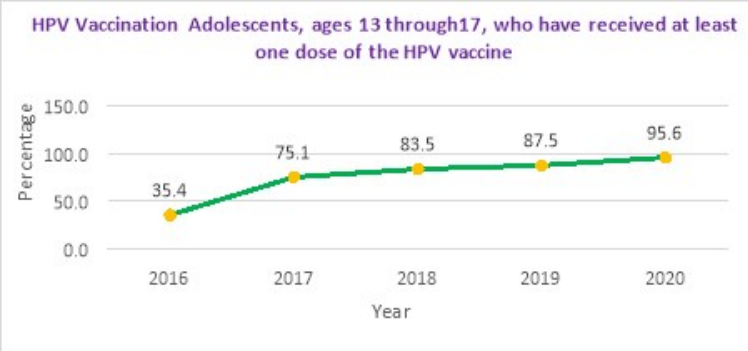
There were a total of 1,146 (71.5%) children ages 19 through 35 months who completed the combined 7-vaccine series services out of a total population of 1,603 children. In 2020, the Immunization focused on data quality of the CNMI's Immunization registry to identify children who are no longer in the CNMI, including those born to tourist mothers who returned to China after birth. Quality improvement efforts, in addition to vaccination strategies enabled the CNMI Immunization program to maintain a high rate of vaccinations during the pandemic.

Through the Immunization Program, the CHCC as a health department, recruits and provides training to Vaccines for Children sites to ensure vaccine handling and safety, proper storage equipment, documentation, and access to the CNMI's Immunization Registry. Currently, there are seven (7) VFC sites. In addition, the Immunization program conducts monthly assessments of childhood vaccination rates and coordinates reminder calls to parents and caregivers and facilitates school based vaccinations to provide expanded access to vaccinations for families throughout the CNMI.

In 2020, together with the MCH, the Immunization program focused its efforts towards supporting clinical integration of services into the CHCC Children's Clinic. In March of 2020, at the same time that the CNMI had declared a state of emergency due to the COVID-19 pandemic, the Immunization program worked to implement childhood vaccination during well-child visits at the Children's Clinic. To support this effort, the program partnered with the providers of the CHCC Children's Clinic to develop a standing order policy for the administration of routine childhood vaccinations (CHCC Operating Policy: 9154) and provided training to clinical staff.

Cognizant of the potential threat of other infectious diseases to the CNMI population, and most especially to the vulnerable members in the community, the MCH program worked with the Immunization program to conduct thorough data reviews and identify children who needed to catchup on routine vaccinations. Utilizing the information, staff were assigned to conduct outreach telephone calls to families and the programs initiated a monthlong vaccination campaign allowing families to drive up to the CHCC parking lot and receive vaccinations. Over 800 patients received vaccinations during the drive thru campaign.

The CNMI has also been able to maintain coverage rates among adolescent receiving vaccinations. Illustrated in the graph below, in 2020, 95.6% (n= 5,517) of teen ages 13 through 17 years had received at least one dose of the HPV vaccine.



Percentage of 13 – 17-year-old in the CNMI with at least one dose of the HPV vaccine

Data Source: CNMI IIS, WebIz

Strategy: Increase community awareness regarding vaccines.

The MCH program utilized social media and print advertisements on local newspapers to promote awareness of the importance of vaccines for children and teens. In addition, educational flyers regarding recommended vaccine schedules were provided to all women prior to discharge after a live birth. In previous years, educational handouts were also shared with community members during community outreach events; however, in 2020, outreach activities were canceled due to the COVID-19 pandemic.

State Performance Measure 6: Percent of resident children, ages 0 thru 17 years, seen at any CHCC site with health insurance coverage.

Health Insurance	2017	2018	2019	2020
Percentage of Children	48.9	52.0	54.1	56
Numerator	7,350	6,892	6,642	5,745
Denominator	15,019	13,255	12,266	10,268

In 2020, a total of 10,268 children ages 0 through 17 years were seen at CHCC. Of these children, 5,745 (56%) children had continuous health insurance coverage

Strategy: Increase access to Medicaid and CHCC Sliding Fee Program application assistance.

The MCH program continues to offer expedited Medicaid application processing for women and children referred to the program, at times facilitating home visits to complete Medicaid application requirements. In May of 2020, the CNMI Medicaid agency submitted a State Plan Amendment which allowed Medicaid application processing under Presumptive Eligibility. This change allowed representatives from the CHCC, such as the MCH Services Coordinator, to make presumptive eligibility (PE) decisions and allowed for 12 months' continuous eligibility for children under age 19. Coverage under Medicaid increased from 14,189 enrollees in FY2019 to 36,637 at the end of FY2020.

Child Health

Discussions during the 5 year needs assessment process regularly focused on the need to address obesity across population domains but beginning at an early age. While there was targeted discussion about children, specifically related to obesity, there was a shift to a broader view of the systemic nature of nutrition and physical activity. Specifically, a change in terminology and definition began to emerge and the priority was reframed. Providing access to healthy food choices and safe physical activity was an issue of both availability and knowledge. The need to educate parents and children on what constitutes a healthy food choice was clearly reflected in the data. At the same time, the real challenge caused by affordable and healthy food in CNMI was discussed. Some families rely on a small convenience stores due to transportation barriers and/or locale, thus connecting other daily issues (poverty, work schedules, children home alone) to unhealthy food choices. Physical activity is impacted by community issues related to neighborhood planning and development and transportation barriers to organized sports. Participants and staff suggested the importance of aligning with existing programs, including home visiting programs, sporting events, schools, and community campaigns, to promote nutrition education and physical activity.
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. CNMI data illustrates a steady increase in the number of children identified as overweight and obese amongst children ages 2 to 5 years over the past 3 years. 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.

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 number of children ages 6 through 11 years who report being active at least 60 minutes a day to 63%, an increase of 10% from baseline.

Strategy: Increase the number of children accessing well-child visits.
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 is an important place to address obesity prevention given the influential role of pediatric primary care providers and their regular contact with families during well-child visits.

Year 2: October 2021– September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Partner with the Immunization program identify children who have upcoming well-child visits due or not up to date with well-child visits.	Child Health Coordinator/ Policy, Partnerships, Communications Coordinator	Standard operating procedure for routine reporting on not up to date children developed.	October 2021 - December 2021
Patient reminders: Contact parents/caregivers via telephone to assist with setting up well-child appointments	Program Assistant	Number of appointments made Number of visits completed	October 2021 – September 2022
Patient recall: Contact parents/caregivers who missed appointments to reschedule	Program Assistant	Number of appointments rescheduled Number of visits completed	October 2021 – September 2022
Utilize social media to promote well-child visits	Communications & Marketing Specialist	Number of social media posts promoting well-child visits	October 2021- September 2022

Evidence Based Strategy Measure (ESM) 8.1: Percentage of 6- 11 year olds accessing well-child visits who report being physically active at least 60 minutes per day.

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 children ages 6 to 11 years who access well-child visits.

Strategy: Increase community awareness on 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.

Year 2: October 2021– September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Develop print and online materials regarding physical activity for children in the CNMI.	Communications & Marketing Specialist	Materials developed (posters, handouts, webpage content, social media content)	October 2021 - December 2021
Collaborate with community agency partners to disseminate communications materials on physical activity.	MICAH Administrator/Child Health Coordinator	Number of MICAH Program partners disseminating materials	October 2021 – September 2022
Air commercials and publish social media content on physical activity.	Program Assistant	Number of advertisements Number of social media views/reach/engagement on the content	January 2021 – September 2022
Identify training module for professionals on nutrition, physical activity, and other obesity related issues	Child Health Coordinator	Training curriculum identified/approved	December 2021
Provide trainings to education professionals and providers	Child Health Coordinator/MICAH Administrator	Number of participants Number of trainings	January 2022-September 2022

Adolescent Health

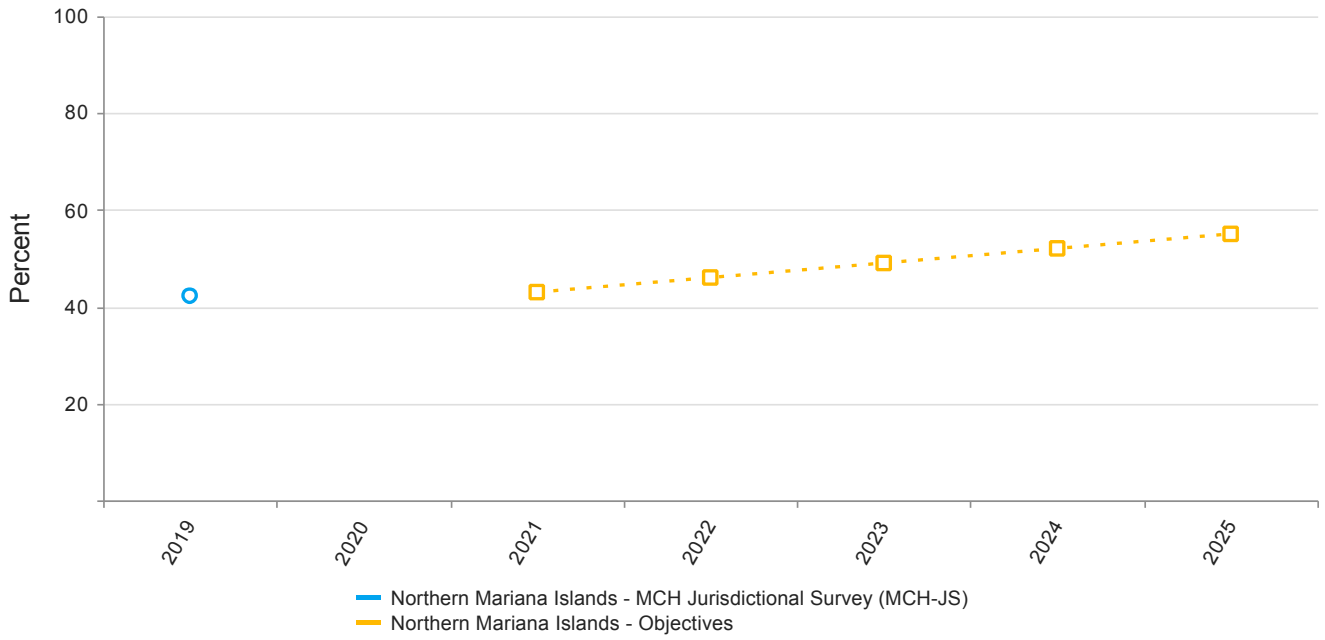
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	Data Not Available or Not Reportable	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	Data Not Available or Not Reportable	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	Data Not Available or Not Reportable	NPM 9 NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	2.6 %	NPM 10 NPM 12
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 10 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	MCH-JS-2019	21.2 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	81.2 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 10
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)	MCH-JS-Age 0-2	Data Not Available or Not Reportable	NPM 10
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)	MCH-JS-Age 10-17-2019	17.5 %	NPM 10
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)	NSCH	Data Not Available or Not Reportable	NPM 10
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)	WIC-2018	8.7 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
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)	YRBSS-2019	21.6 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	20.6	NPM 10

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**
Annual Objective		
Annual Indicator	42.4	42.4
Numerator	2,593	2,593
Denominator	6,119	6,119
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.0	46.0	49.0	52.0	55.0	58.0

Evidence-Based or –Informed Strategy Measures

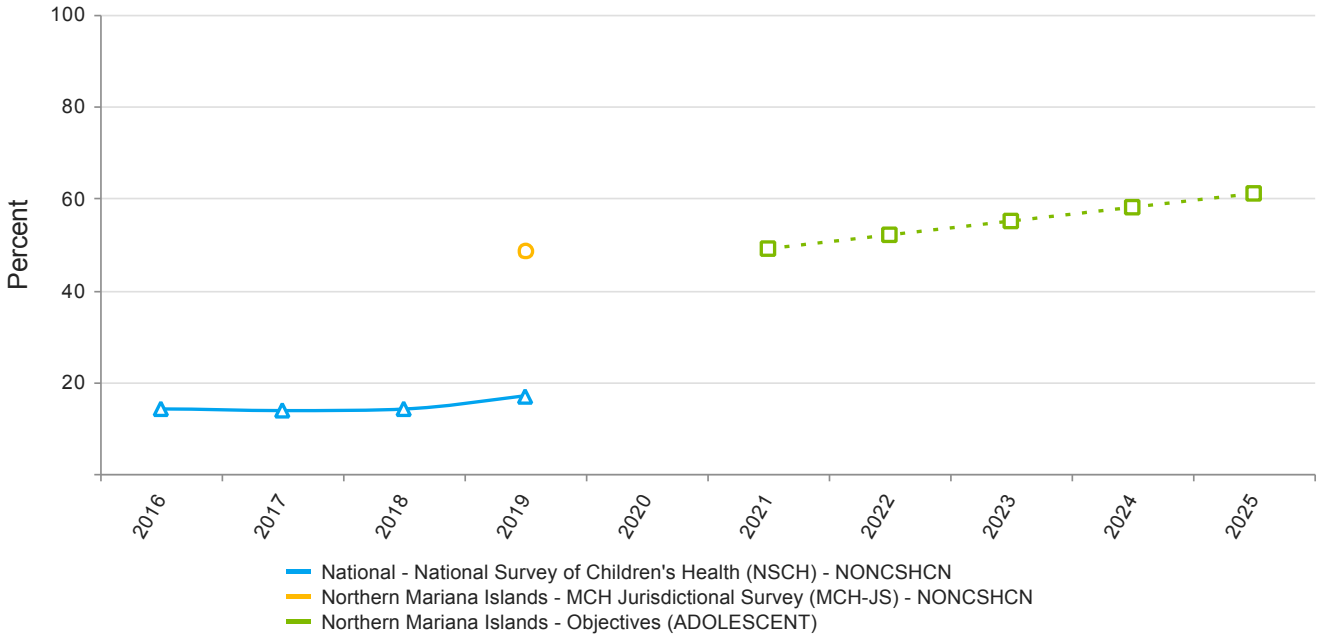
ESM 10.1 - Percentage of adolescents accessing preventive care who report being referred by their school.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	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 - Adolescent Health - NONCSHCN

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	49.0	52.0	55.0	58.0	61.0	64.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percentage of students and/or parents who indicate increased knowledge about the importance of transition after presentations.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

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 number of adolescents who access well visits by 10%.	
Strategies	
Partner with the Public School System to increase the number of adolescents accessing adolescent health visits.	
ESMs	Status
ESM 10.1 - Percentage of adolescents accessing preventive care who report being referred by their school.	Active

NOMs

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

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

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

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

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

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

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

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

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

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

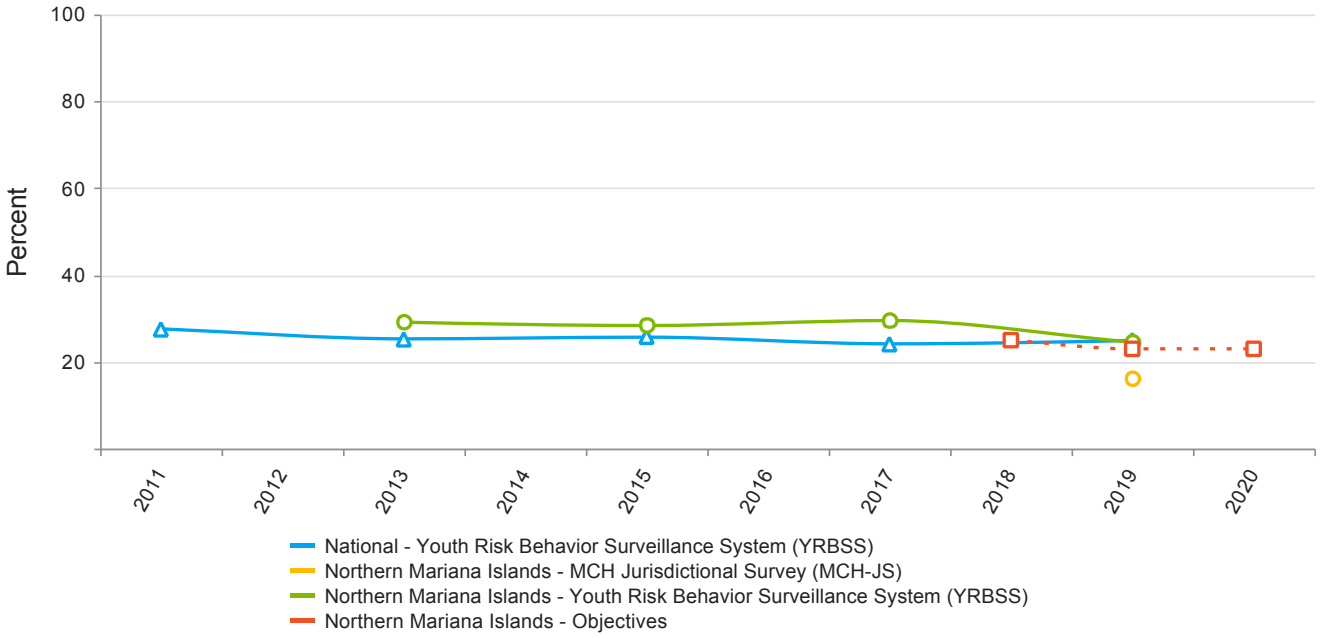
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

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

State Action Plan Table (Northern Mariana Islands) - Adolescent Health - Entry 2	
Priority Need	
Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful	
NPM	
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	
Objectives	
By 2025, increase the number of adolescents ages 12 through 17 years who receive transition services by 10% from baseline.	
Strategies	
Provide education, presentations, and support to high school students in making transition into adult healthcare.	
ESMs	Status
ESM 12.1 - Percentage of students and/or parents who indicate increased knowledge about the importance of transition after presentations.	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

2016-2020: National Performance Measures

2016-2020: NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Indicators and Annual Objectives



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	75	25	25	23	23
Annual Indicator	28.5	28.5	29.4	29.4	24.4
Numerator	934	934	953	953	764
Denominator	3,277	3,277	3,240	3,240	3,126
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2019

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	23	23
Annual Indicator	16.1	16.1
Numerator	988	988
Denominator	6,119	6,119
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 9.1 - Percent of schools that have implemented evidence based programs to address bullying.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		15	45	50	55
Annual Indicator	0	45	40	40	40
Numerator	0	9	8	8	8
Denominator	20	20	20	20	20
Data Source	CNMI Public School System	CNMI Public School System	CNMI Public School System	CNMI Public School System	CNMI Public School System
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: State Performance Measures

2016-2020: SPM 4 - Percent of high school students that report thoughts of suicide.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		20	22	21	21
Annual Indicator	22.8	25	25	28.5	28.5
Numerator	543	481	481	654	654
Denominator	2,385	1,922	1,922	2,297	2,297
Data Source	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey
Data Source Year	2015	2017	2017	2019	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: SPM 5 - Birth rate among 15-17 year olds

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		13	7	7	6
Annual Indicator	11	8.4	10.8	11.8	7.8
Numerator	14	11	14	15	10
Denominator	1,273	1,302	1,301	1,267	1,284
Data Source	CNMI HVSO/US International Census estimates	CNMI HVSO/US International Census estimates	CNMI HVSO/US International Census estimates	CNMI HVSO/US International Census estimates	CNMI HVSO/US International Census estimates
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

ADOLESCENT HEALTH

The MCH Program continues to utilize partnerships to be able to expand its reach within the adolescent population group and continues to partner with the STD/HIV prevention and treatment program, the CHCC Women's and Children's Clinic, Immunization Program, Dental Clinic, and the Public School System. In 2020, schools in the CNMI transitioned to virtual (online) learning due to the COVID-19 pandemic. This resulted in outreach school clinics that were planned to be suspended. However, programs continued to partner with the school system, and while limited, the MICAH section was able to provide zoom presentations to middle and high school students as well as young adults at the Northern Marianas College.

National Performance Measure 9: Percent of adolescent ages 12 through 17 years who are bullied or who bully others

Bullying	2016	2017	2018	2019	2020
Percentage of Adolescents	28.5	28.5	29.4	29.4	24.4
Numerator	934	934	953	953	764
Denominator	3,277	3,277	3,240	3,240	3,126

Maternal & Child Health (MCH) Jurisdictional Survey Data

In 2020 the MCH Jurisdictional Survey was conducted in the CNMI. Data gathered from the survey indicated that there were 16.1 percent of adolescent ages 12 through 17 years who were bullied in the CNMI.

The CNMI utilizes the bi-annual Youth Risk Behavior Survey (YRBS) to report on this measure. The most recent YRBS completed was in 2019. Therefore, the CNMI is reporting on this measure utilizing the 2019 YRBS results, which is the most recent *federally available data* on bullying. The data show some decline in the percent of adolescent aged students reporting bullying, with 24.4 percent (n= 764) reporting being bullied in 2020 compared to 29.4 percent (n= 953) in 2019.

Strategy: Expand the use of bullying prevention programs in public schools.

Many of the challenges for engaging schools in 2019 were a direct result of the disaster caused by super typhoon Yutu at the start of the year. Schools were closed for a couple of months as they were used as shelters for families who were displaced by the disaster. And just as the schools and the rest of the CNMI was transitioning out of the disaster period caused by super typhoon Yutu, the COVID-19 pandemic was announced, causing schools to transition to online learning and health department personnel to respond to the public health emergency. Outreach and youth conference events during the 2020 school year were placed on suspended status as a result of the COVID-19 pandemic.

Strategy: Increase parent engagement in bullying prevention.

Plans for increasing parent engagement in bullying prevention for FY2020 involved conducted presentations and

working with Parent Teacher Student Associations (PTSA) groups from the middle and high school campuses throughout the CNMI. These activities were put on hold in order for the MCH program and other health department staff to respond to the COVID-19 pandemic. PTSA groups also focused on addressing emerging issues for the schools that were caused by the COVID-19 pandemic.

Evidence Based Measure 9.1: Percent of schools that have implemented evidence based programs to address bullying in schools.

Bullying Prevention	2017	2018	2019
Percentage of Schools	45	40	40

In 2018, MCH program conducted an assessment to determine the types of evidence based curriculums being utilized by public schools to address bullying. There are a total of 20 public school campuses across all school levels throughout the CNMI. Results from the assessment concluded that 9 (45 %) of the 20 schools reported utilizing an evidence based curriculum to address bullying prevention. For 2018, 8 of the 20 schools reported to be currently utilizing an evidence based curriculum to address bullying prevention. Of the 20 schools that were surveyed, 8 (40%) reported that they were currently utilizing an evidence-based curriculum, 9 (45%) reported that they were not currently utilizing an evidence based curriculum, and 3 (15%) schools did not respond. Two of the 9 that reported no current use of a curriculum stated that they had just placed an order for the Second Step curriculum and will be working towards implementing that program in the next coming school year. Additionally, 3 of the 9 who reported no current use indicated interest in implementing a curriculum to support bullying prevention efforts. Three of the schools were unresponsive to the survey. To date, the MCH program has not been able to complete an updated survey of schools to determine any changes or improvements in the use of evidence-based curriculum for the prevention of bullying.

State Performance Measure 4: Percent of high school student that report thoughts of suicide.

Suicide Thoughts	2016	2017	2018	2019	2020
Percentage of High School Students	22.8	25.0	25.0	28.5	28.5
Numerator	543	481	481	654	654
Denominator	2,385	1,922	1,922	2,297	2,297

The CNMI utilizes the bi-annual Youth Risk Behavior Survey (YRBS) to report on this measure. Information available via the CDC's Youth Online website indicates results of the 2019 YRBS conducted in the CNMI. Data from the report illustrates that 28.5 percent (n= 654) of high school students reported thoughts of suicide, this is a 3.5 percent increase from the previous YRBS conducted in 2017. The YRBS is conducted bi-annually and will be conducted again in 2021.

Strategy: Increase teen access to mental/behavioral health supports and education.

As a strategy for increasing access to mental/behavioral supports and education, the MCH program partnered with the Hawaii Youth Services Network (HYSN) to provide training for creating an inclusive environment for the LGBTQ+ members of the CNMI community, including those adolescents. The training was facilitated by Vicky Kobayashi and Darlene Dubrall who are both GLSEN certified trainers. GLSEN is a non-profit, US based organization that works to promote LGBTQ+ inclusivity, particularly among k-12 schools.

The training was completed by a total of 31 CHCC staff and community partners, including representatives from the Northern Marianas College and the Public School System. The first workshop, "The LGBT Community: Understanding Sexual Orientation and Gender Identity," focused on providing an overview of the many terms and vocabulary that are frequently used in the LGBTQ+ community, including the difference between sexual orientation and gender identity. The workshop was designed to improve communication and messaging that involves LGBTQ+ topics. The second workshop, "Creating LGBT Inclusive Environments," provided information on creating a safe and inclusive environment for both LGBTQ+ clients and coworkers. The content was designed to help participants think critically about their organization's policies regarding LGBTQ+ people, and how they could be improved, understand LGBTQ+ people and their health needs, and improve communication to create an affirming workplace for everyone.

State Performance Measure 5: Teen birth rate among 15- to 17-year-olds

Teen Births	2016	2017	2018	2019	2020
Teen Births per 1,000	11.0	8.4	10.8	11.9	7.8
Numerator	14	11	14	15	10
Denominator	1,273	1,302	1,301	1,267	1,284

There are substantial social and economic costs related to teen births as indicated through long term impacts on teens and their children[i]. Teen pregnancy significantly contributes to high school drop-out rates and lower educational attainment among teen mothers. The CNMI MCH Program has worked diligently to engage partners such as the Family Planning program and the Public School System in efforts towards teen pregnancy prevention and reduction in teen births among CNMI youth. In 2016, the rate of teen births was 11.0 per 1,000 females ages 15 through 17 years. This rate decreased to 8.48 per 1,000 in 2017. The CNMI experienced a slight increase in 2018 with a rate of 10.8 per 1,000 females ages 15 through 17 years and a rate of 11.9 per 1,000 in 2019. In 2020, the CNMI saw a decline in teen births among 15- to 17-year-olds with a rate of 7.8 per 1,000. The data reported for this measure was obtained through the birth registry from the CNMI Health & Vital Statistics Office (HVSO).

Strategy: Increase access to confidential adolescent health services.

Through partnership with the Public School System, the MCH and Family Planning program continue to work on activities that focus on increasing access to confidential teen health services available through the CHCC, including HIV/STD testing and treatment and Family Planning services. Flyers and social media advertisements were published to increase awareness among the adolescent population regarding confidential services for teens available at the CHCC. Additionally, the Family Planning program conducted virtual classroom presentations with a

total of 164 attendees from middle and high school classes in the CNMI. Through Title V funds, contraceptives are made available for teens seeking services to prevent pregnancy. In 2020, a total of 107 teens 17 years and below accessed services through the Family Planning program with an additional 124 between the ages of 18- and 19-years receiving services.

[i] Centers for Disease Control and Prevention 9CDC). (2017). About Teen Pregnancy. Retrieved on June 30, 2018 from https://www.cdc.gov/teenpregnancy/about/index.htm

Adolescent Health

Adolescent health continues to be a significant component in the collaboration between MICAH Programs and the local Public School System. 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, making utilizing a school based approach to providing preventive programs 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, job training and healthy recreation are also important objectives under this priority. The need to promote positive coping mechanisms can be accomplished with yearly mental health screenings that can lead to suicide prevention and addressing bullying/bullies. Preventative health well visits for adolescents which are fully covered under insurance can promote overall physical health (immunizations, healthy eating, and oral health) as well as social emotional health. 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: 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 number of adolescents who access well visits to 55%, an increase of 13% from baseline.

Strategy: Partner with the Public School System to assess number of teens who are not up to date with annual teen visits and facilitate referral to MCH for access.

Year 2: October 2021 – September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Work with the school system to identify teens who are not up to date with annual teen well visits	Child Health Coordinator/ MICAH Administrator	Protocol developed/finalized	October 2021-December 2022
Work with Public School System to develop and finalize a referral mechanism for teen well visits	MICAH Coordinator/ Policy, Partnerships, and Communications Coordinator	Referral protocol finalized	January 2022-February 2022
Develop brochures for schools to distribute to high school parents	Communications & Marketing Specialist	Brochures developed/finalized	October 2021-December 2022
Evaluate referral process	SSDI Project Coordinator	Evaluation report complete	August 2022

Evidence Based Strategy Measure (ESM) 10.1: Percentage of adolescents identified and referred to MCH for well visits.

To measure the impact of the strategy on the priority area and objective, the MCH program will work with the Public School System to identify the total number of teens who are not up to date with annual preventive visits and identify the number referred to MCH for well visits. The program will then assess the number of teens who actually completed a preventive visit among the total referred for services by the school system.

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 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 of 13% from baseline.

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

Year 1: October 2021 – September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Develop presentation and training materials	Child Health Coordinator/CSHCN Coordinator	Presentation developed/finalized.	October 2021- December 2021
Partner with Public School System and Parent Teacher Organization to develop training/presentation schedule	Child Health Coordinator/CSHCN Coordinator	Scheduled developed/finalized.	January 2022
Develop survey to gather feedback on the presentations	SSDI Project Coordinator	Survey developed	January 2022- March 2022
Conduct presentations to high school students and/or their parents	Child Health Coordinator/CSHCN Coordinator/MICAH Administrator	Number of presentations Number of participants Number of surveys completed	April 2022- June 2022

Children with Special Health Care Needs

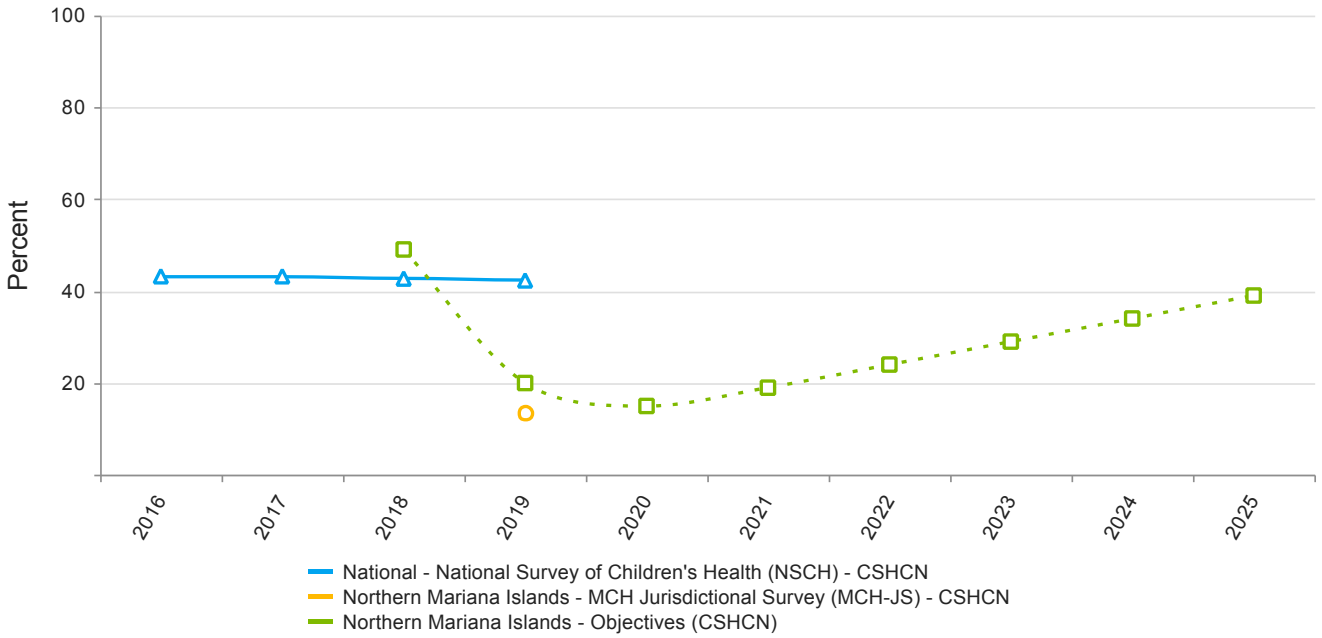
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	2.6 %	NPM 11 NPM 12
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	MCH-JS-2019	21.2 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	81.2 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	MCH-JS-2019	6.1 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH	Data Not Available or Not Reportable	NPM 11

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			49	20	15
Annual Indicator	46.8	46.8	19.6	19.6	13.3
Numerator	37	37	54	54	141
Denominator	79	79	276	276	1,059
Data Source	CYSHCN Survey	CYSHCN Survey	CSHCN Survey	CSHCN Survey	MCH-JS-CSHCN
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	19.0	24.0	29.0	34.0	39.0	44.0

Evidence-Based or –Informed Strategy Measures

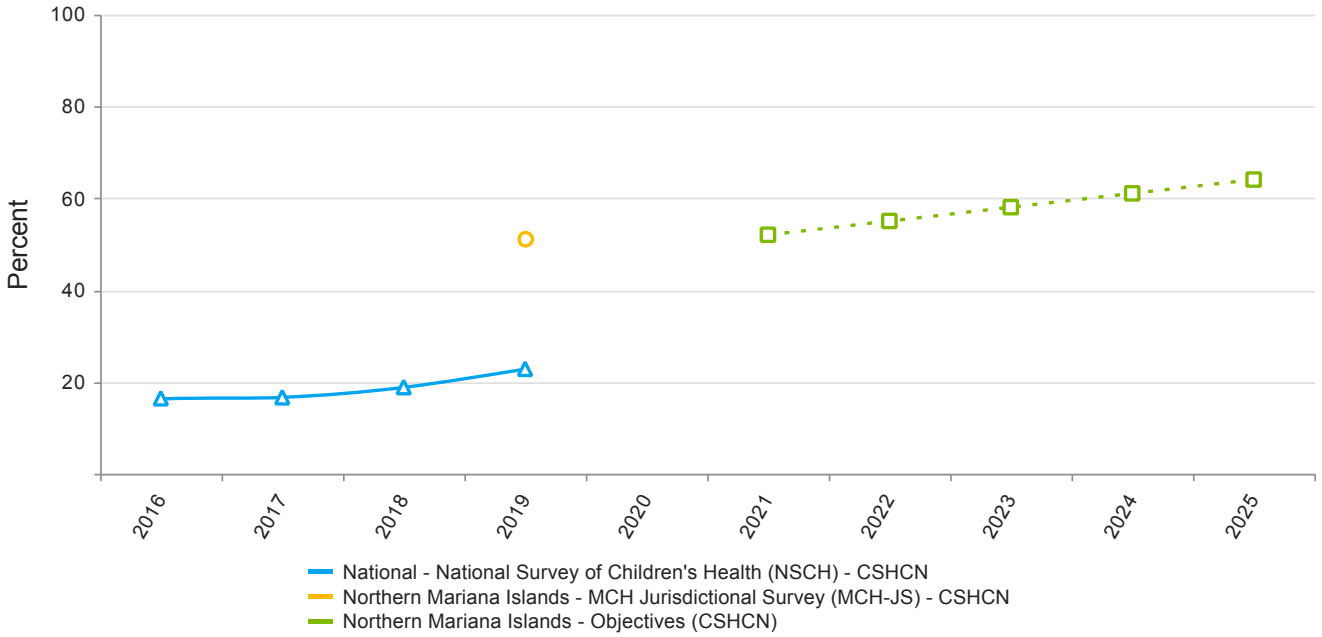
ESM 11.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	55.0

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**
Annual Objective		
Annual Indicator	51.0	51.0
Numerator	183	183
Denominator	358	358
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	52.0	55.0	58.0	61.0	64.0	67.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percentage of students and/or parents who indicate increased knowledge about the importance of transition after presentations.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

State Action Plan Table

State Action Plan Table (Northern Mariana Islands) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Helping parents/caregivers navigate the health care system for coordinated care	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
By 2025, increase the number of CSHCN who report having a medical home by 10% from baseline.	
Strategies	
Conduct outreach and provide peer support to families of children and youth with special healthcare needs.	
ESMs	Status
ESM 11.1 - Percentage of families served by the Family to Family Health Information Center who reported having a medical home.	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

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

Priority Need

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

NPM

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

Objectives

By 2025, increase the number of adolescents ages 12 through 17 years who receive transition services by 10% from baseline.

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 students and/or parents who indicate increased knowledge about the importance of transition after presentations.	Active

NOMs

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

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

In 2020, the MCH program continued work on activities focused on early identification of children with special health need and worked to improve access to care coordination services for families of children identified. Through Title V block grant funds, the program supports two full time Service Coordinators that provide support to families of infants and toddlers who are enrolled in Early Intervention (EI) Services. The MICAH unit also has a Newborn Screener & Family Support Coordinator who oversees CHCC population health efforts on newborn screening and family support for children identified as deaf or hard of hearing, those diagnosed with a condition through metabolic screening, and families who are seen through the Shriner's outreach clinic.

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

In 2020, the MCH Jurisdictional Survey was conducted in the CNMI. The purpose of the JMCHS was to increase data capacity at the jurisdictional level for reporting on National Performance and Outcome Measures in the Title V MCH Block Grant reports and to enhance tracking of identified priorities aimed at improving the health of MCH populations. Data was collected in households with mothers with children under 18 years of age, including children with special health care needs. A targeted sample size of about 200 respondents was determined to be sufficient to reduce sampling errors or biases. Survey questionnaires consisted of MCH core questions and supplemental set of questions customized to the need of the jurisdiction. A total of 218 surveys were completed.

Measures		2020
NOM 17.2	Percent of children with special health care needs ages 0 through 17, who receive care in a well-functioning system	2.6%
NOM 18	Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	21.2%
NOM 19	Percent of children, ages 0 through 17, in excellent of very good health	81.2%
NOM 25	Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	6.1%

Source: CNMI MCH Jurisdictional Survey

Medical Home Measures

Year	Survey/Source Information	Percentage Measure
2017	Survey of Children enrolled in EI	46.8
2018	Survey of Children enrolled in SPED & EI	19.6
2020	MCH Jurisdictional survey	13.3

Data gathered from the CNMI MCH Jurisdictional Survey indicated that 13.3 percent of CSHCN, ages 0 through 17 in 2020 reported having a medical home. Compared to other surveys used to collect information on children

accessing medical homes, in 2017 a survey conducted on just infants and toddlers enrolled in EI indicated 46.8 had a medical home while just 19.6 of children enrolled in EI and SPED that were surveyed in 2018 reported having a medical home. The MCH program encountered some challenges in regards to data collection among the CNMI CSHCN population. In 2018, the program was transitioning methodology to include the broader SPED population. And then in the subsequent year, super typhoon Yutu had caused challenges in being able to return to the school system to administer the survey. In 2020, with the implementation of the MCH Jurisdictional Survey, the program transitioned to utilizing the information collected from the jurisdictional survey to inform the performance measure on medical home for CSHCN.

Strategy: Increase family engagement activities.

Families that are identified through screening programs, the hospital NICU, Pediatrics department, and partner agencies such as the Public School System refer families to the Family to Family (F2F) Health Information Center. The CNMI F2F focuses on building partnerships with parents to support parent leaders on Saipan, Tinian, and Rota. The F2F also employs a Family Support Specialist that provides support to families with CSHCN to overcome the stigma and empower parents to voice their opinion regarding their children.

Key activities include promoting access to primary care and care coordination and providing support and guidance through linkages to other community programs. The program identifies opportunities for collaboration across the MCH domains and continues to develop and strengthen relationships with local, state, and national networks.

The CNMI F2F had officially opened its doors to the community just as the COVID-19 pandemic was declared a public health emergency in the CNMI. All programmatic activities were temporarily suspended as program staff restationed to respond to the emergency activities. When staff transitioned back to programs, virtual platforms were utilized to reach out to families in the community by providing learning sessions on various topics. The virtual learning sessions helped to promote the newly established F2F center to the community and provided an avenue for educating families and professionals.

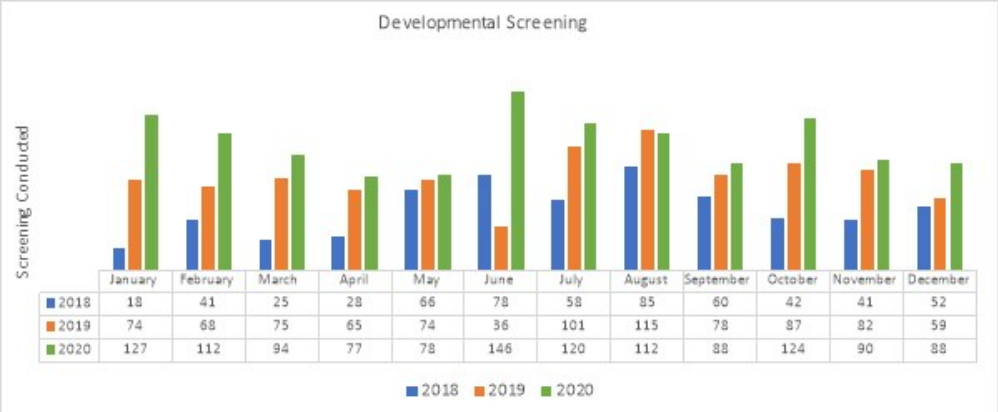
Below is the table with the information on learning sessions offered in 2020.

Month	Topic	Title	Trainer/Facilitator	Participants
February	Strep Throat and Rheumatic Fever	Strep Throat and Its Complication	Dr. Julio Pena, CHCC Pediatrician	22
May	Coping Strategies & Stress Management for Parent/Caregivers	The Caregiver's Wellness	Kim Mendiola, LPC	21
May	Audiology- The Ear & Hearing	Audiology- The Ear & Hearing	Dr. Angie Mister, Audiologist	34
July	Well- Child Visits	Well-Child Care: A Check-up for Success	Heather Taylor, NP, CHCC Children's Clinic	42
August	Early Intervention Services	What is Early Intervention?	Robin Palacios, M.Ed, Early Intervention Program Director	58
September	Medicaid Application Process	Medicaid 101	Antonio Yarobwemal, MS, MCH Services Coordinator	21

The MCH program collaborated with the medical providers, early intervention services team, and other partnering

agencies by providing professional development and in-service trainings to help other agencies understand the connections between child and CSHCN serving programs. Improvement in service coordination amongst programs and healthcare providers have produced positive effect with family engagement.
The program developed a position that supported screening activities at the Children's Clinic and to assist with facilitating referrals to the Early Intervention Services and the Special Education Program. With the staff located at the clinic since 2019, substantial increases have been identified in the number of developmental screenings conducted at the CHCC Children's Clinic in 2019 and 2020 compared to the previous years.

Developmental Screening among infants and children seen at the CHCC Children's Clinic, 2018-2020



Data Source: MCH Developmental Screening Database

Developmental screening rate has increased 27% compared to the previous year. A total of 1,256 screenings were conducted at the Children's Clinic during Well Child Care in 2020. 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.

Number of children screened with ASQ and identified as needing monitoring or below developmental cut-off, 2018 – 2020.

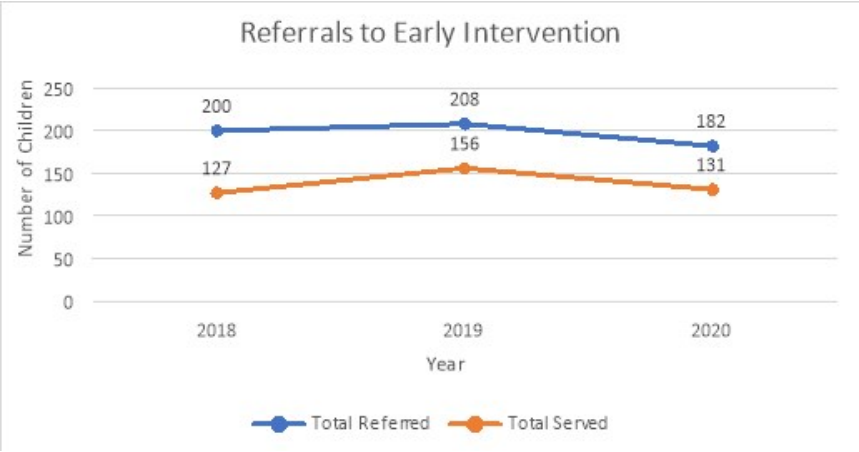
Year	Total Number Screened	Number Identified for monitoring or at below cut-off
2018	594	205
2019	914	334
2020	1,256	389

Source: MCH Program

The MCH Program tracks developmental screening through the use of the Ages and Stages Questionnaire, 3rd edition, conducted by the CHCC Children's Clinic. In 2018, there were a total of 594 parent administered developmental screens completed with 205 children identified as requiring additional monitoring or referral to Early Intervention services. In 2019, a total of 914 children were screened and 334 identified as needing additional follow-up or referral to EI and in 2020 the total number screened was 1,256 with 389 identified as requiring follow-up or

referral to EI.

Total Referrals to Early Intervention Services, 2017- 2019



Source: CNMI Early Intervention Program

A total of 131 families were served through the Early Intervention Program in 2020. Of those families, 60 children were with established condition and 71 were identified as developmental delay. Early Intervention referral data reports a decrease in both number of referrals to EI and number of families served compared to the previous year. The overall decrease may be due to the COVID-19 pandemic. Services were ceased temporarily; when services resumed, services were offered virtually.
In 2020, 63% of infants and toddlers referred to EI were from the CHCC.

CNMI Newborn Hearing Screening, 2018- 2020

	2018	*2019*	*2020*
Births	1258	909	654
Screened	977	903	648
Inpatient Pass	977	652	505
Inpatient Refer	281	247	138
Outpatient Pass	215	214	133
Outpatient LTFU	54	22	5
Outpatient Refer to DAE	12	11	5
DAE Pass	5	3	3
DAE Hearing Loss	4	10	1
EI Referral	2	9	1

Source: CNMI EHDI-IS

As in the previous year, 2020 data illustrates that 99% of babies born in the CNMI received a newborn hearing screening before one month of age. Of the babies screened, only one was diagnosed with hearing loss and was referred to the Early Intervention Program.

Newborn Bloodspot Screening, 2018 - 2020

	YEAR 2018						YEAR 2019						YEAR 2020					
	TOTAL LIVE BIRTHS		RESIDENTS		TOURIST		TOTAL LIVE BIRTHS		RESIDENTS		TOURIST		TOTAL LIVE BIRTHS		RESIDENTS		TOURIST	
Total live births	1262	100%	681	54.0%	581	46.0%	909	100%	697	76.7%	212	23.3%	654	100.0%	631	96.5%	23	3.5%
# of Meatbolic Screening	527	41.8%	480	91.1%	47	8.9%	674	74.1%	612	90.8%	62	9.2%	589	90.1%	566	96.1%	23	3.9%
Presumptive Positive	21	4.0%	21	4.4%	0	0.0%	13	1.9%	13	100.0%	0	0.0%	10	1.7%	10	100.0%	0	0.0%
# of Positive Diagonosis	1	4.8%	1	4.8%	0	0.0%	7	53.8%	7	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Referred for treatment	1	100%	1	100%	0	0.0%	7	100%	7	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Data Source: CNMI –EHDI IS

Of the 654 live births in 2020, 90% completed a newborn bloodspot screening. This is an increase compared to the prior year's rate of 74% and a significant increase compared to 42% in 2018.

There are a couple of factors that may have impacted screening rates. The first is that overall birth rates had significantly decreased due to restrictions placed on the CNMI tourist visa waiver which impacted the number of tourist births in the CNMI. CNMI screening programs have had challenges with tourist mothers requesting hospital discharge early after birth and declining screening. We have also had challenges with lost to follow up with the same demographic when asked for a return to the CHCC laboratory for bloodspot samples to be collected.

Additionally, through the work of the CHCC chairwoman of pediatrics, Dr. LaPonsie, and Laboratory Directory, Dr. Dauterman, the CHCC was able to modify its newborn bloodspot screening policy to enable daily shipment of bloodspot samples to the Oregon Public Health laboratory, causing decreases in lost to follow up among infants whose parents are asked to return for samples to be collected.

The COVID-19 pandemic affected the Shriner's Hospital Outreach services in 2020. Shriner's have been visiting the CNMI twice in a year to conduct outreach services to CSHCN with orthopedic and musculoskeletal conditions. In 2020, outreach was only conducted once, serving a total of 146 children from ages 0 to 18 years of age and 12 telehealth clinics were conducted. Additionally, there were no patients sent to Honolulu for specialist care nor surgeries due to the COVID restrictions. This is a decrease compared to 2019, where 205 CNMI children were seen through Shriner's Hospital outreach and 7 referred to Honolulu, Hawaii for additional specialist care, including surgeries.

Children with Special Healthcare Needs (CSHCN)

The MCH program will continue to focus its efforts on improving early identification and screening programs for identifying and connecting children with special healthcare needs with early intervention services. Early intervention improves and enhances the development of a child with developmental delays, special needs, or other concerns. For MCH, 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 2020 Jurisdictional MCH Survey conducted, there were 13.3 percent of children with special health care needs, ages 0 through 17, who reported having a medical home in the CNMI. The program has made efforts for improving in collaboration with the medical providers, early intervention services team, and other partnering agencies by providing professional development and in-service trainings to help understand and provide coordinated services to the CSHCN population.

Additionally, priorities specific to the needs of children and youth with special health care needs, though not exclusive, 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 needs assessment process, it became apparent that family support was emerging as a high need and that those supports include understanding available resources. Understanding the resources and how to navigate them can reduce caregiver stress. This priority exemplifies the collaboration and partnership building principles that CHCC MICAH programs promote and is willing to sustain so that all children with health care needs are children first.

Priority Need 6: 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 number of CSHCN who report having a medical home to 39%, an increase of 26% from baseline.

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

Year 2: October 2021 – September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Develop outreach and referral protocol.	Child Health Coordinator/MICAH Administrator	Protocol approved.	October 2021-December 2022
Partner with the Public School System SPED department to refer CSHCN to Family Support services.	CSHCN Coordinator	Partnership MOU developed Number of referrals to F2F Support	December 2021-September 2022
Conduct outreach/in-service to teachers & support staff at schools and child care centers	CSHCN Coordinator/Child Health Coordinator	Number of presentations Number of participants	January 2022-April 2022
Develop a survey to assess number of families who report having a medical home.	SSDI Project Coordinator	Survey Developed	July 2022-September 2022

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 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.

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 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 of 13% from baseline.

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

Year 2: October 2021 – September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Partner with public schools Youth Advisory Panel (YAP) leadership groups to conduct youth let transition presentations	Child Health Coordinator/CSHCN Coordinator/MICAH Administrator	Presentation material and schedule finalized	October 2021-January 2022
Support YAP leadership group presentations on transitions to high school students	Child Health Coordinator/CSHCN Coordinator/MICAH Administrator	Number of presentations Number of participants	February 2021-June 2021
Partner with the CNMI Disability Network Partners (DNP) to host transition conferences on Saipan, Tinian, and Rota	CSHCN Coordinator/MICAH Administrator	Number of participants	February 2021-May 2021

According to the American Academy of Pediatrics, a medical home is an approach for providing comprehensive primary care and should be: accessible, family centered, continuous, comprehensive, coordinated, compassionate, and culturally effective[i].

As part of efforts for increasing the number of children and youth with special healthcare needs provided with a medical home, the MCH program will conduct outreach to families, particularly families of CSHCN, and provide parents/caregivers with assistance in navigating the healthcare and other community systems to ensure they are connected to medical homes. Through the newly established Family to Family (F2F) Health Information Center, a CHCC MICAH program, families will be provided with peer support and assistance with accessing programs and services such as Medicaid, Social Security, Early Intervention, Medical Referral, and others available to families in the CNMI or through the national F2F network.

[i] National Resource Center for Patient/Family Centered Medical Home. (n.d.) What is a Medical Home. Retrieved on June 26, 2019 from https://medicalhomeinfo.aap.org/overview/Pages/Whatisthemedicalhome.aspx

Cross-Cutting/Systems Building

State Performance Measures

SPM 2 - Percentage of health department (CHCC) staff that receive training on MCH priorities and/or related strategies.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

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 health department (CHCC) staff that receive training on MCH priorities and/or related strategies.

Objectives

By 2025, increase the number of MCH serving professionals who complete training on MCH priorities and topics by 25% from baseline.

Strategies

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.

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building

The needs assessment process indicated that lack of resources were contributing to stressors across all population domains. Lack of services were an issue, but the bigger issue was lack of knowledge of services. This systemic issue suggests the need for trained, qualified professionals of all levels to deliver services across the MCH population domains. Seeking the appropriate care for the maternal and child health care population is critical to ensure that the population needs are being met. For quality care to be delivered it's important that the professionals interfacing with this population are properly informed and trained to provide this care. Ensuring professionals that serve the MCH populations have adequate training impacts individuals from birth and continues throughout adulthood.

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.

Objectives: By 2025, increase the number of MCH serving professionals who complete training on MCH priorities to 25%.

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

Year 2: October 2021 – September 2022

Activity	Lead Person	Measure/Evaluation	Timeframe
Work with the CHCC CE Coordinator and Professional & Organizational Development (POD) Coordinator on developing training schedule	Professional & Organizational Development (POD) Coordinator/ MICAH Administrator	Schedule finalized	October 2021-December 2021
Develop CHCC New Employee On-boarding materials to educate new employees on CHCC MICAH Programs, priorities, and services	Policy, Partnerships, and Communications Coordinator/MICAH Administrator	Material finalized	January 2022-February 2022
Coordinate training sessions for MCH serving professionals	Policy, Partnerships, and Communications Coordinator/MICAH Administrator	Number of training sessions offered Number of training participants	April 2022-September 2022

III.F. Public Input

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

In the past, the MCH Program participated in annual community events such as the Annual Red Cross Walk-a-Thon and Safe Jamboree. Since these events are attended by thousands of community members, the MCH Program participated to ensure the community is aware of the program's priorities, services, and goals. Additionally, the MCH Program coordinates the Annual CNMI Women's Health Month in May, where the program uses the opportunity to communicate to partner agencies, community members, and other stakeholders regarding the CNMI MCH program's priorities, activities, and strategies for improving health outcomes. However, for the 2022 Application/2020 Annual Report, the MCH program did not have the opportunity to attend outreach events due to their cancellation as a result of the COVID-19 pandemic.

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

Copies of the application summary were also provided to management of CHCC population health programs, which included the Non-Communicable Disease Bureau, HIV/STD Prevention Program, Immunization Program, TB/Chest Clinic, healthcare providers, and resident directors on the islands of Tinian and Rota. Considering that the annual report/application is a lengthy document at almost 300 pages, the CNMI Title V Program made available and disseminated an overview/executive summary of the annual block grant application/annual report for partners, stakeholders, and the CNMI community as part of the public input process.
Feedback to the application/annual report is on-going as of the time of the submission of the document to HRSA. Updates will be provided during the state update section of the block grant review and feedback incorporated into activities and reports in FY2022.

III.G. Technical Assistance

In light of our priorities, activities, and emerging issues, we have identified the following as potential areas for technical assistance support. These TA priorities are continued from the last reporting year. Due to the COVID-19 response and vaccination efforts in the CNMI, the MCH program did not have the opportunity to engage HRSA in TA support. The CNMI MCH program will utilize the HRSA MCHB Technical Assistance Form to request assistance once TA priorities are finalized:

- ***Preparedness for MCH Populations-*** Technical assistance and support will be sought to enhance current territorial emergency preparedness plans to address specific MCH populations and areas of focus. Needs and services specific to Women, Children, including Children with Special Healthcare Needs (CSHCN) during times of disaster response and recovery will need to be identified and clearly articulated into emergency preparedness planning and efforts. The CNMI Title V MCH Program will coordinate with the CHCC Public Health Hospital Emergency Preparedness (PHHEP) office on this effort and will leverage partnerships from other CNMI preparedness and emergency response agencies.
- ***Evaluation of Community Awareness/Promotional Materials-*** Community awareness activities are important components of MCH programs in the CNMI and a mechanism for engaging community members in programs, services, and educational information. The MCH program has identified a need for technical assistance to develop a plan to effectively evaluate the impact of community awareness activities and promotional materials on the health and well-being of the MCH populations targeted.
- ***Child Lead Poisoning Prevention-*** Elevated blood lead levels among children in the CNMI has been identified as an emerging issue. The CHCC Children's Clinic provider team worked to improve lead screening among children seen at well-child visits. The Children's Clinic saw an increase in the number of children identified with elevated blood lead levels. The CHCC attempted to apply for funding through notice of funding opportunity CDC-RFA-EH21-2102 Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children but was informed via email by the CDC Lead Poisoning Prevention and Environmental Health Tracking Branch that the CNMI did not qualify due to our status as a *territory.* Therefore, the CNMI Title V Program will explore opportunities to utilize HRSA MCHB Technical Assistance to build capacity and strengthen lead poisoning prevention and surveillance efforts for the MCH population.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MICAH Org Chart 07222021.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Northern Mariana Islands

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 466,540	
A. Preventive and Primary Care for Children	$ 149,186	(31.9%)
B. Children with Special Health Care Needs	$ 151,545	(32.4%)
C. Title V Administrative Costs	$ 41,049	(8.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 341,780	
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)	$ 487,995	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 487,995	
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	
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	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 11,832,430	

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

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 463,450		$ 465,091	
A. Preventive and Primary Care for Children	$ 142,676	(30.8%)	$ 140,019	(30.1%)
B. Children with Special Health Care Needs	$ 147,455	(31.8%)	$ 142,257	(30.5%)
C. Title V Administrative Costs	$ 42,132	(9.1%)	$ 40,881	(8.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 332,263		$ 323,157	
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)	$ 474,700		$ 517,315	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 474,700		$ 517,315	
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)	$ 938,150		$ 982,406	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 2,059,790		$ 3,047,227	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 2,997,940		$ 4,029,633	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 65,040	$ 55,821
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,000,000	$ 825,285
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 248,000	$ 219,367
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 200,000	$ 393,058
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 400,000	$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000	$ 48,316
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN	$ 96,750	$ 113,298
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations		$ 1,392,082

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: This amount is inclusive of the base award in the amount of $1,055,075 and the ARPA Supplemental Funding in the amount of $3,515,745 ending on 06/30/2024.	
2.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: The WIC grant was recently added under the Maternal, Infant, Child & Adolescent Health (MICAH) Programs. Therefore, this grant will be directly under the management of the MICAH Administrator.	
3.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The expenditure figure reported is from the EHDI FY2019 grant. The budget period was extended up through 06/30/2021. This will be the final grant the CNMI will be receiving.	
4.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The expenditure figure reported is from the MIECHV FY2019 grant. The budget year is from 09/30/2016 - 09/29/2021.	
5.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning**

	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: There is an increase in the amount expended than the amount budgeted because the program requested a carryover of funds from the previous budget year and was able to expend some of those funds. In addition, the program also received supplemental funds the program was able to expend.	
6.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The CNMI continues to receive the Oral Health grant, however, it is no longer managed under the Maternal, Infant, Child & Adolescent Health (MICAH) Programs Administrator. In addition, it is no longer under the MICAH Programs.	
7.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Family Professional Partnership/CSHCN**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: There is a slight increase in the amount expended than the amount budgeted because the program requested a carryover of funds from the previous budget year and was able to expend some of those funds.	
8.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The Vaccines for Children Grant was recently added to the Maternal, Infant, Child & Adolescent Health (MICAH) Programs. The grant is currently being managed under the MICAH Administrator. The expenditure amount is also inclusive of the COVID Supplemental funds that were expended within the FY20 budget period.	

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 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 37,880	$ 37,488
2. Infants < 1 year	$ 37,880	$ 37,487
3. Children 1 through 21 Years	$ 149,186	$ 140,019
4. CSHCN	$ 151,545	$ 142,257
5. All Others	$ 49,000	$ 66,959
Federal Total of Individuals Served	$ 425,491	$ 424,210

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 80,517	$ 90,994
2. Infants < 1 year	$ 80,517	$ 90,994
3. Children 1 through 21 Years	$ 177,756	$ 216,606
4. CSHCN	$ 149,205	$ 118,721
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 487,995	$ 517,315
Federal State MCH Block Grant Partnership Total	$ 913,486	$ 941,525

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 22 Application Budgeted	FY 20 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	$ 265,045	$ 251,796
3. Public Health Services and Systems	$ 201,495	$ 213,295
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 466,540	$ 465,091

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 458,995	$ 480,762
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 132,034	$ 145,435
B. Preventive and Primary Care Services for Children	$ 177,756	$ 216,606
C. Services for CSHCN	$ 149,205	$ 118,721
2. Enabling Services	$ 0	$ 0
3. Public Health Services and Systems	$ 29,000	$ 36,553
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		$ 480,762
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		$ 480,762
Non-Federal Total	$ 487,995	$ 517,315

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: 654 **Data Source Year: 2020**

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	589 (90.1%)	10	0	0

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Hearing Screening	646 (98.8%)	5	1	1 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

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

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

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Total live births: 654 # bloodspot screening: 589 (90.1%)	
2.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: 10 infants screened out of range results	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: 0 infants with confirmed diagnosis	
4.	**Field Name:**	**Hearing Screening - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: 5 referred for Diagnostic Audiological Evaluation (DAE) 3 passed DAE- no hearing loss identified 1- confirmed with hearing loss 1- was transferred off-island/relocated due to medical referral.	

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 2020

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	645	67.9	0.0	16.3	15.8	0.0
2. Infants < 1 Year of Age	654	68.0	0.0	16.2	15.8	0.0
3. Children 1 through 21 Years of Age	11,046	36.8	0.0	19.5	43.7	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,060	0.0	0.0	0.0	0.0	100.0
4. Others	1,424	45.7	0.0	32.7	21.6	0.0
Total	13,769					

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	780	No	645	100.0	645	645
2. Infants < 1 Year of Age	766	No	654	100.0	654	654
3. Children 1 through 21 Years of Age	18,672	No	18,417	60.0	11,050	11,046
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,205	No	1,060	100.0	1,060	1,060
4. Others	32,610	No	15,519	9.2	1,428	1,424

^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:	**2020**
	Field Note: Number of pregnant women served reflects the total number of women with live births in the CNMI for year 2020. Title V funds supports direct and enabling services for women who access services through the Commonwealth Healthcare Corporation, which operates the only birthing facility in the CNMI.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Total number of infants less than 1 year served is based on total live births in 2020, those served during well-child visits at the CHCC children's clinic and through dental visit through the Oral Health program by the Public Health dental clinic.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Value is based on the total number of children ages 1 through 21 years of age who were served at Commonwealth Health Care Corporation (CHCC).	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Value is based on total number of CSHCN who were provided care coordination services.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Value is based on the number of women ages 22 years and above who visited Commonwealth Health Center Corporation for health services at the Women's Clinic and Oral Health	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Denominator value is based on the total number of women with live births in the CNMI for year 2020. Numerator value based on the total number of women with live births in the CNMI that occurred at the CHCC hospital. CNMI has only one hospital/birthing center. All deliveries in the CNMI occur at the CHCC hospital.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Denominator value is based on the CY2020 total live births. Numerator value is based on the total number of live births in the CNMI that occurred at the CHCC hospital. CNMI has only one hospital/birthing center. All deliveries in the CNMI occur at the CHCC hospital.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Denominator value is based on the CY2020 US Census population estimate. Numerator value is based on the total number of child ages 1 through 21 years of age served by the Commonwealth Healthcare Corporation.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Children with special healthcare needs value is based on the total number of children 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, and data capacity efforts. The CHCC operates the only hospital and all emergency departments in the CNMI.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Denominator value based on US Census Estimate for year 2020 for the number women aged 22 years and older in the CNMI. Numerator value is based on the total number of women ages 22 years and above served by the Commonwealth Healthcare Corporation Women's Clinic and Oral Health	

Data Alerts:

1.	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.
2.	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.
3.	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.
4.	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.
5.	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.

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

State: Northern Mariana Islands

Annual Report Year 2020

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	645	7	0	0	0	246	352	40	0
Title V Served	645	7	0	0	0	246	352	40	0
Eligible for Title XIX	438	0	0	0	0	112	293	33	0
2. Total Infants in State	654	7	0	0	0	247	359	41	0
Title V Served	654	7	0	0	0	247	359	41	0
Eligible for Title XIX	445	0	0	0	0	112	299	34	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**

Field Note:
Total number of unduplicated women who gave birth in 2020

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

State: Northern Mariana Islands

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(670) 287-7718	(670) 287-7718
2. State MCH Toll-Free "Hotline" Name	MCH Services	MCH Services
3. Name of Contact Person for State MCH "Hotline"	Antonio Yarobwemal	Antonio Yarobwemal
4. Contact Person's Telephone Number	(670) 287-7718	(670) 287-7718
5. Number of Calls Received on the State MCH "Hotline"		1,539

B. Other Appropriate Methods	2022 Application Year	2020 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	www.chcc.gov.mp	https://www.chcc.gov.mp/maternalchildhealth.php
4. Number of Hits to the State Title V Program Website		592
5. State Title V Social Media Websites	https://www.facebook.com/cnmipophealth	https://www.facebook.com/cnmipophealth
6. Number of Hits to the State Title V Program Social Media Websites		66,726

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Northern Mariana Islands

1. Title V Maternal and Child Health (MCH) Director	
Name	Heather Pangelinan
Title	MICAH Programs Administrator
Address 1	PO Box 500409
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 236-8723
Extension	
Email	hsantosmch@gmail.com

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Danielle Youn Jung Su
Title	Child Health Coordinator
Address 1	PO Box 500409
Address 2	
City/State/Zip	Saipan / MP / 96950
Telephone	(670) 664-8700
Extension	
Email	dsumch@gmail.com

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

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Northern Mariana Islands

Application Year 2022

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 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 Notes for Form 9:

None

Field Level Notes for Form 9:

None

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
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**
2019	77.0 %	10.0 %	1,252	1,627

Legends:

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

State Provided Data	
	2020
Annual Indicator	55.0
Numerator	347
Denominator	631
Data Source	CNMI HEALTH AND VITAL STATISTICS OFFICE (HVSO)
Data Source Year	2020

NOM 1 - Notes:

Numerator and denominator reflects the number of live births from non-tourist mothers.

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	
	2020
Annual Indicator	122.3
Numerator	8
Denominator	654
Data Source	HVSO
Data Source Year	2020

NOM 2 - Notes:

Numerator: Represents the total number of live births from women who experienced maternal Eclampsia, Transfusion, Ruptured Uterus Unplanned Hysterectomy, Admission to ICU, and Unplanned OR procedure as indicated in the 2020 HVSO dataset

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**
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	
	2020
Annual Indicator	0.0
Numerator	
Denominator	
Data Source	
Data Source Year	

NOM 3 - Notes:

There were no Maternal deaths in 2020

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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	
	2020
Annual Indicator	10.4
Numerator	68
Denominator	654
Data Source	CHCC Health and Vital Statistics Office
Data Source Year	2020

NOM 4 - Notes:

The numerator and denominator are based on non-tourist births

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**
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**
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	
	2020
Annual Indicator	10.9
Numerator	71
Denominator	654
Data Source	CHCC HVSO
Data Source Year	2020

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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	
	2020
Annual Indicator	28.1
Numerator	184
Denominator	654
Data Source	CHCC HVSO
Data Source Year	2020

NOM 6 - Notes:

None

Data Alerts: None

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

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

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	14.5 ϟ	4.6 ϟ	10 ϟ	692 ϟ
2018	17.5 ϟ	5.6 ϟ	10 ϟ	573 ϟ
2017	27.3 ϟ	8.8 ϟ	10 ϟ	366 ϟ
2016	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2015	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2014	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2013	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2012	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2011	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2010	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2009	NR ⚑	NR ⚑	NR ⚑	NR ⚑

Legends:

⚑ Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2020
Annual Indicator	9.1
Numerator	6
Denominator	656
Data Source	CHCC HVSO
Data Source Year	2020

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2020
Annual Indicator	7.6
Numerator	5
Denominator	654
Data Source	CHCC HVSO
Data Source Year	2020

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	NR	NR	NR	NR
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	
	2020
Annual Indicator	7.6
Numerator	5
Denominator	654
Data Source	CHCC HEALTH AND VITAL STATISTICS OFFICE
Data Source Year	2020

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	
Denominator	
Data Source	
Data Source Year	

NOM 9.3 - Notes:

No post-neonatal mortality in 2020

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	
	2020
Annual Indicator	152.9
Numerator	1
Denominator	654
Data Source	CHCC HEALTH AND VITAL STATISTICS OFFICE (HVSO)
Data Source Year	2020

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	NR	NR	NR	NR
2018	NR	NR	NR	NR
2018	NR	NR	NR	NR
2017	NR	NR	NR	NR
2016	NR	NR	NR	NR
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	654
Data Source	HVSO
Data Source Year	2020

NOM 10 - Notes:

Numerator value is less than 10 and therefore not reportable.

Data Alerts:

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

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

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

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	654
Data Source	RPMS
Data Source Year	2020

NOM 11 - Notes:

There were zero diagnosis of neonatal abstinence syndrome in 2020

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
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

State Provided Data	
	2020
Annual Indicator	64.6
Numerator	536
Denominator	830
Data Source	CHCC Dental Clinic
Data Source Year	2020

NOM 14 - Notes:

The CHCC Dental Outreach program was interrupted due to the COVID-19 pandemic.

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**
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	
	2020
Annual Indicator	29.2
Numerator	2
Denominator	6,854
Data Source	HVSO and U.S. International Census Estimates
Data Source Year	2020

NOM 15 - Notes:

None

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**
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	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	10,024
Data Source	HVSO and U.S. International Census Estimates
Data Source Year	2020

NOM 16.1 - Notes:

No Adolescent mortality in 2020

Data Alerts:

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

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	4,712
Data Source	CHCC HVSO and US International Census Estimates
Data Source Year	2020

NOM 16.2 - Notes:

No motor vehicle deaths by adolescent aged 15 through 19 years in 2020

Data Alerts:

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

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
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	
	2020
Annual Indicator	0.0
Numerator	0
Denominator	4,712
Data Source	CHCC HVSO and U.S. International Census Estimates
Data Source Year	2020

NOM 16.3 - Notes:

No deaths due to suicide by adolescents aged 15 through 19 years

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
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
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
2019	2.4 % ϟ	1.0 % ϟ	343 ϟ	14,237 ϟ

Legends:

ϟ 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
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
2019	21.2 % ϟ	14.2 % ϟ	101 ϟ	476 ϟ

Legends:

ϟ 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
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
2018	8.7 %	0.7 %	136	1,569
2016	7.8 %	0.7 %	111	1,418
2014	9.0 %	0.7 %	162	1,808
2012	11.3 %	0.7 %	253	2,239
2010	14.1 %	0.8 %	304	2,157

Legends:

Indicator has a denominator <50 and is not reportable

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

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

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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**
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	
	2020
Annual Indicator	28.7
Numerator	4,523
Denominator	15,776
Data Source	CHCC HVSO and U.S. International Census estimates
Data Source Year	2020

NOM 21 - Notes:

Numerator: Number of children ages 0 through 17 who visited the hospital without health insurance in 2020

Denominator: U.S. International Census Estimates year 2020

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	
	2020
Annual Indicator	71.5
Numerator	1,146
Denominator	1,603
Data Source	CHCC WebIz
Data Source Year	2020

NOM 22.1 - Notes:

None

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	
	2020
Annual Indicator	29.7
Numerator	4,437
Denominator	14,933
Data Source	CNMI Weblz
Data Source Year	2020

NOM 22.2 - Notes:

Data was obtained from the CNMI Immunization Information System (IIS), also called the Weblz.

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	
	2020
Annual Indicator	95.6
Numerator	5,517
Denominator	5,771
Data Source	CHCC WebIZ
Data Source Year	2020

NOM 22.3 - Notes:

None

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	
	2020
Annual Indicator	98.0
Numerator	5,653
Denominator	5,771
Data Source	CHCC WebIZ
Data Source Year	2020

NOM 22.4 - Notes:

None

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	
	2020
Annual Indicator	98.4
Numerator	5,676
Denominator	5,771
Data Source	CHCC WebIZ
Data Source Year	2020

NOM 22.5 - Notes:

None

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**
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	
	2020
Annual Indicator	15.1
Numerator	32
Denominator	2,126
Data Source	CHCC HVSO and U.S. International Census estimates
Data Source Year	2020

NOM 23 - Notes:

The teen birth rate data captures non-tourist teen, ages 15 through 19 years, residing in the CNMI in year 2020

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
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
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**
Annual Objective		56
Annual Indicator	55.5	55.5
Numerator	6,544	6,544
Denominator	11,784	11,784
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	19	12	19	20	56
Annual Indicator	12.1	18.1	18.7	19.7	41.9
Numerator	1,464	1,425	1,437	1,516	3,238
Denominator	12,096	7,863	7,690	7,689	7,721
Data Source	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CNMI Pap Exam Data, US Census Population Estimate	CHCC Preventive Visits and US international census
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	57.0	59.0	61.0	63.0	65.0	67.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Numerator data obtained from the CHCC RPMS Database and the Family Planning Program FPAR database. Denominator data from the US Census International Database. Data is for CY 2016. Numerator information does not include data for women who might have had a preventive visit at a private clinic.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Numerator data obtained from the CHCC RPMS Database and the Family Planning Program FPAR database. Denominator data from the 2010 US Census Population Estimator Database. Data is for CY 2017. Numerator information does not include data for women who might have had a preventive visit at a private clinic. Please note a significant decrease in the Census population estimate (denominator) between years 2016 and 2017 by 4,233.	
3.	**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.	
4.	**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	

NPM 4A - Percent of infants who are ever breastfed

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

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	45	94	96	96	97
Annual Indicator	95.5	94.7	95.8	96.5	93.3
Numerator	1,162	1,145	1,209	877	610
Denominator	1,217	1,209	1,262	909	654
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	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	97.0	98.0	98.0	98.0	98.0	98.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	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:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data for this National Performance Measure obtained through the CNMI Health and Vital Statistics Office. The denominator value is based on the total number of live births in the CNMI for CY2017. Numerator value is based on the total number of infants breastfed at discharge after delivery by HVSO.	
3.	**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.	

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

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	40	3	4	4	5
Annual Indicator	1.7	2.5	2.5	1.1	0.4
Numerator	9	13	12	5	2
Denominator	535	518	486	470	544
Data Source	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program	CNMI WIC Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	6.0	6.0	7.0	7.0	7.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	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:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Numerator data source is the CNMI WIC program and represents that number of enrolled 6 month old infants during the reporting year who were exclusively breastfed through 6 months. Denominator data represents the number of 6 month old infants enrolled in WIC during the reporting year.	
3.	**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.	

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**
Annual Objective		
Annual Indicator	52.7	52.7
Numerator	2,769	2,769
Denominator	5,253	5,253
Data Source	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	55.0	57.0	59.0	61.0	63.0	65.0

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**
Annual Objective		
Annual Indicator	42.4	42.4
Numerator	2,593	2,593
Denominator	6,119	6,119
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	43.0	46.0	49.0	52.0	55.0	58.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator: 2019 CHCC RPMS query of Preventive Visit using ICD-10, CPT codes and provider's narratives. Denominator: US International Census estimates of the number of individuals ages 12 to 17 years for 2019	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator: 2020 CHCC RPMS query of Preventive Visit using ICD-10, CPT codes and provider's narratives. Denominator: US International Census estimates of the number of individuals ages 12 to 17 years for 2020	

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

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

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			49	20	15
Annual Indicator	46.8	46.8	19.6	19.6	13.3
Numerator	37	37	54	54	141
Denominator	79	79	276	276	1,059
Data Source	CYSHCN Survey	CYSHCN Survey	CSHCN Survey	CSHCN Survey	MCH-JS-CSHCN
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	19.0	24.0	29.0	34.0	39.0	44.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	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 the CYSHCN survey that responded "yes" on the healthcare services they receive for their child(ren) being coordinated, ongoing, and comprehensive. The survey is conducted every 2 years in the CNMI.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Denominator value is based on the total number of surveys completed through the CYSHCN survey. Numerator value is based on the number of families who completed the CYSHCN survey that responded "yes" on the healthcare services they receive for their children being coordinated, ongoing, and comprehensive. The survey is conducted every two years in the CNMI.	
3.	**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.	
4.	**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.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data obtained is based on the 2020 Maternal and Child Health Jurisdictional Survey.	

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**
Annual Objective		
Annual Indicator	51.0	51.0
Numerator	183	183
Denominator	358	358
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	52.0	55.0	58.0	61.0	64.0	67.0

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**
Annual Objective		
Annual Indicator	48.4	48.4
Numerator	2,788	2,788
Denominator	5,761	5,761
Data Source	MCH-JS-NONCSHCN	MCH-JS-NONCSHCN
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	49.0	52.0	55.0	58.0	61.0	64.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Northern Mariana Islands

2016-2020: NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	13	15
Annual Indicator	18.8	18.8
Numerator	490	490
Denominator	2,609	2,609
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			11	13	15
Annual Indicator	4	10.2	12.1	33.4	20
Numerator	103	215	321	694	489
Denominator	2,602	2,112	2,656	2,077	2,441
Data Source	Childrens Clinic Log/ US International Census	CHCC Childrens Clinic /US International Census	CHCC Childrens Clinic /US International Census	CHCC Childrens Clinic /US International Census	CHCC Childrens Clinic /US International Census
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Denominator value based on Census International Database Population Estimator that equals the total number of children ages 9 months through 71 months as indicated for the Northern Mariana Islands. Numerator value is based on the total number of children ages 9 months through 71 months screened with a parent administered developmental screening tool at the CHCC Children's Clinic. Please note that the numerator value does not include children seen at private clinics. However, it is also important to note that a majority of the pediatric providers in the Northern Mariana Islands provide care through the CHCC.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Denominator value based on Census International Database Population Estimator that equals the total number of children ages 9 months through 35 months as indicated for the Northern Mariana Islands. Numerator value is based on the unduplicated number of children ages 9 months through 35 months screened with a parent administered developmental screening tool at the CHCC Children's Clinic and MIECHV Home Visiting Program. Please note that the numerator value does not include children seen at private clinics. However, it is also important to note that a majority of the pediatric providers in the Northern Mariana Islands provide care through CHCC.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator is data gathered from the CNMI Home Visting Program and CHCC Children's Clinic. There was a total unduplicated number of children ages 9 through 35 months that had a parent administered developmental screening at least once in 2018. The denominator data is based on the US Census population estimate.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator Number of ASQ screening performed on children ages 9 through 35 months at Children's Clinic. Denominator is based on the US Census population estimate.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of ASQ screenings performed on children ages 9 through 35 months at Children's Clinic. Denominator is based on the US Census population estimate.	

2016-2020: NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	75	25	25	23	23
Annual Indicator	28.5	28.5	29.4	29.4	24.4
Numerator	934	934	953	953	764
Denominator	3,277	3,277	3,240	3,240	3,126
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2019

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	23	23
Annual Indicator	16.1	16.1
Numerator	988	988
Denominator	6,119	6,119
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	14	15
Annual Indicator	31.5	31.5
Numerator	5,221	5,221
Denominator	16,554	16,554
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			13	14	15
Annual Indicator	13.6	11.9	12.3	15.4	6.2
Numerator	2,025	1,900	1,934	2,359	937
Denominator	14,847	16,010	15,719	15,281	15,009
Data Source	CHCC Dental Clinic / US International Census	CHCC Dental Clinic / US International Census	CHCC Dental Clinic / US International Census	CHCC Dental Clinic / US International Census	CHCC Dental Clinic / US International Census
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Numerator data is reflective of the un-duplicated number of children ages 1 through 17 that received preventive oral health services through the CHCC Dental Clinic. Denominator information is obtained through the US Census International Database population estimator.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Numerator data is reflective of the un-duplicated number of children ages 1 through 17 that received preventive oral health services through the CHCC Dental Clinic. Denominator information is obtained through the US Census International Database population estimator for all children ages 1 through 17 years in the Northern Mariana Islands. Note that the data does not include visits made to private dental clinic providers in the CNMI. Additionally, the islands of Tinian and Rota have no private dental clinic; services to these outlying islands are provided through outreach by the CHCC dental clinic and thus reflected in the data provided.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data obtained from the CHCC Dental Clinic/Oral Health Program. A total of 1,934 children ages 1 thru 17 years completed a preventive dental visit in 2018. Denominator data is obtained through the US Census Population Estimate.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data obtained from the CHCC Dental Clinic/Oral Health Program. A total of 2,359 children ages 1 thru 17 years completed a preventive dental visit in 2019. Denominator data is obtained through the US Census Population Estimate.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data obtained from the CHCC Dental Clinic/Oral Health Program. A total of 937 children ages 1 thru 17 years completed a preventive dental visit in 2020. Denominator data is obtained through the US Census Population Estimate.	

Form 10
State Performance Measures (SPMs)

State: Northern Mariana Islands

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		45	47	49	51
Annual Indicator	43.4	45.8	47.5	47.9	55
Numerator	319	297	323	334	347
Denominator	735	648	680	697	631
Data Source	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO	CNMI HVSO
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	53.0	55.0	55.0	60.0	60.0	60.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	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.	
2.	**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.	
3.	**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.	

SPM 2 - Percentage of health department (CHCC) staff that receive training on MCH priorities and/or related strategies.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of women of childbearing age screened for anemia.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	15	10	13	12
Annual Indicator	66.4	66.9	59.1	59.5
Numerator	1,590	1,656	1,348	1,151
Denominator	2,395	2,476	2,279	1,936
Data Source	CHCC RPMS	CHCC RPMS	CHCC RPMS	CHCC RPMS
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Revision of the SPM to reflect Anemia Screening rates.
Numerator value represents total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery who were screened for anemia.

Denominator value represents the total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Revision of the SPM to reflect Anemia Screening rates.
Numerator value represents total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery who were screened for anemia.

Denominator value represents the total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Revision of the SPM to reflect Anemia Screening rates.
Numerator value represents total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery who were screened for anemia.

Denominator value represents the total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery.

4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Revision of the SPM to reflect Anemia Screening rates.
Numerator value represents total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery who were screened for anemia.

Denominator value represents the total unduplicated number of women, ages 15-44 years, seen at the Women's Clinic, Hospital OB unit, and Labor & Delivery.

2016-2020: SPM 3 - Percent of children receiving routine vaccines.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		68	50	52	54
Annual Indicator	42.9	48.9	51.5	55.6	71.5
Numerator	949	1,092	1,157	1,178	1,146
Denominator	2,214	2,232	2,247	2,120	1,603
Data Source	CNMI Immunization Program WEBiz	CNMI Immunization Program WebIz	CNMI Immunization Program WebIz	CNMI Immunization Program WebIz	CNMI Immunization Program WebIz
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Numerator value reflects the number of children ages 19 through 35 months who have completed the combined 7 vaccine series. Denominator value obtained from CNMI Immunization database representing the total number of children ages 19 through 35 months who are active in the system.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Numerator value reflects the number of children ages 19 through 35 months who have completed the combined 7 vaccine series. Denominator value obtained from CNMI Immunization database representing the total number of children ages 19 through 35 months who are active in the system.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator value reflects the number of children ages 19 through 35 months who have completed the combined 7 vaccine series. Denominator value obtained from CNMI Immunization database representing the total number of children ages 19 through 35 months who are active in the system.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator value reflects the number of children ages 19 through 35 months who have completed the combined 7 vaccine series. Denominator value obtained from CNMI Immunization database representing the total number of children ages 19 through 35 months who are active in the system.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator value reflects the number of children ages 19 through 35 months who have completed the combined 7 vaccine series. Denominator value obtained from CNMI Immunization database representing the total number of children ages 19 through 35 months who are active in the system.	

2016-2020: SPM 4 - Percent of high school students that report thoughts of suicide.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		20	22	21	21
Annual Indicator	22.8	25	25	28.5	28.5
Numerator	543	481	481	654	654
Denominator	2,385	1,922	1,922	2,297	2,297
Data Source	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey
Data Source Year	2015	2017	2017	2019	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data source is the YRBS. The YRBS in the Northern Mariana Islands is conducted every two years. School YR 2016-17 just completed the survey and data will be available in 2018.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data is based on results from the 2017 High School CNMI Youth Risk Behavior Survey.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data is based on results from the 2017 High School CNMI Youth Risk Behavior Survey.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator and Denominator were based on the results of the 2019 CNMI High School Youth Risk Behavior Survey.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator and Denominator were based on the results of the 2019 CNMI High School Youth Risk Behavior Survey.	

2016-2020: SPM 5 - Birth rate among 15-17 year olds

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		13	7	7	6
Annual Indicator	11	8.4	10.8	11.8	7.8
Numerator	14	11	14	15	10
Denominator	1,273	1,302	1,301	1,267	1,284
Data Source	CNMI HVSO/US International Census estimates	CNMI HVSO/US International Census estimates	CNMI HVSO/US International Census estimates	CNMI HVSO/US International Census estimates	CNMI HVSO/US International Census estimates
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Numerator value represents number of births to resident mothers ages 15 through 17 years. Denominator value based on US Census population estimate of the number of females ages 15 through 17 years.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Numerator value represents number of births to resident mothers ages 15 through 17 years. Denominator value based on US Census population estimate of the number of females ages 15 through 17 years.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator value represents number of births to resident mothers ages 15 through 17 years. Denominator value based on US Census population estimate of the number of females ages 15 through 17 years.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator value represents number of births to resident mothers ages 15 through 17 years. Denominator value based on US Census population estimate of the number of females ages 15 through 17 years.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator value represents number of births to resident mothers ages 15 through 17 years. Denominator value based on US Census population estimate of the number of females ages 15 through 17 years.	

2016-2020: SPM 6 - Percent of resident children, ages 0 thru 17 years, seen at any CHCC site with health insurance coverage.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			59	61
Annual Indicator	48.9	52	54.1	56
Numerator	7,350	6,892	6,642	5,745
Denominator	15,019	13,255	12,266	10,268
Data Source	CHCC RPMS	CHCC RPMS	CHCC RPMS	CHCC RPMS
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Numerator Number of children, ages 0 thru 17 years, seen at CHCC with continuous health insurance coverage. Denominator Number of children, ages 0 thru 17 years seen at CHCC	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator Number of children, ages 0 thru 17 years, seen at CHCC with continuous health insurance coverage. Denominator Number of children, ages 0 thru 17 years seen at CHCC	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator Number of children, ages 0 thru 17 years, seen at CHCC with continuous health insurance coverage. Denominator Number of children, ages 0 thru 17 years seen at CHCC	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator Number of children, ages 0 thru 17 years, seen at CHCC with continuous health insurance coverage. Denominator Number of children, ages 0 thru 17 years seen at CHCC	

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

State: Northern Mariana Islands

ESM 1.1 - Percentage of women who report an increase in access to preventive services.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Percentage of workplace presentation participants who report increase in knowledge and skills regarding workplace breastfeeding policies.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.1 - Percentage of 6- 11 year old children accessing well-child visits who report being physically active at least 60 minutes per day.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Percentage of adolescents accessing preventive care who report being referred by their school.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0	55.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.1 - Percentage of students and/or parents who indicate increased knowledge about the importance of transition after presentations.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	15.0	20.0	25.0	30.0	35.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Percent of women ages 18 thru 44 seen at mobile clinic outreach events.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	5	7	8
Annual Indicator	2.9	1.6	3.3	1.9	0
Numerator	351	124	251	147	0
Denominator	12,096	7,863	7,690	7,689	7,721
Data Source	MCH Program Records	MCH Program Records	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Denominator Value based on Census Population Estimate. Numerator value based on the number of women ages 18-44 seen during Mobile clinic events recorded through MCH program records.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Denominator Value based on Census Population Estimate. Numerator value based on the number of women ages 18-44 seen during Mobile clinic events recorded through MCH program records.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Denominator Value based on Census Population Estimate. Numerator value based on the number of women ages 18-44 seen during Mobile clinic events recorded through MCH program records.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator value based on the number of women ages 18-44 seen during Mobile clinic events recorded through MCH program records. Denominator Value based on Census Population Estimate	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator: The mobile clinic was not accessible or available during outreach events. Denominator Value based on Census Population Estimate	

2016-2020: ESM 1.2 - Percent of women ages 18 thru 44 seen at the Family Planning Program.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		9	11	14	14
Annual Indicator	9.2	13.4	16.5	17.5	17.5
Numerator	1,117	1,057	1,267	1,344	1,353
Denominator	12,096	7,863	7,690	7,689	7,721
Data Source	CNMI Family Planning Program Records	CNMI Family Planning Program Records	CNMI Family Planning Program	CNMI Family Planning Program	CNMI Family Planning Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Denominator data obtained through the US Census Population Estimator. Numerator is based on the total number of unduplicated patients seen through the MCHB Family Planning Program.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Numerator is based on the total number of unduplicated female patients ages 18 44 years seen at the MCHB Family Planning Program. Denominator data obtained through the US Census Population Estimator.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Numerator is based on the total number of unduplicated female patients ages 18 44 years seen at the MCHB Family Planning Program. Denominator data obtained through the US Census Population Estimator.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator is based on the total number of unduplicated female patients ages 18 44 years seen at the MCHB Family Planning Program. Denominator data obtained through the US Census Population Estimator.	

2016-2020: ESM 4.2 - Percent of infants enrolled in Home Visiting breastfed through 6 months.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		53	55	50	52
Annual Indicator	51.6	56.5	45.1	49.1	70
Numerator	33	13	23	27	28
Denominator	64	23	51	55	40
Data Source	MIECHV Home Visiting Program	MIECHV Home Visiting	MIECHV Home Visiting	MIECHV	MIECHV Home Visiting
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Denominator value represents the total number of 6 month old infants receiving home visitation services in 2016. Numerator information represents the number of 6 month old infants receiving home visitation services who were breastfed through 6 months.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 13 out of 23 six month old babies served by the Home Visiting Program in 2017 reported to be breastfed at six months.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 23 out of 51 six month old babies served by the Home Visiting Program in 2018 reported to be breastfed at 6 months.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 27 out of 55 six month old babies served by the Home Visiting Program in 2019 reported to be breastfed at 6 months.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 28 out of 40 of six month old babies served by the Home Visiting Program in 2020 reported to be breastfed at 6 months.	

2016-2020: ESM 6.1 - Percent of children who complete an ASQ screening at the CHCC Children's Clinic during a well-child visit.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		40	55	63	65
Annual Indicator	38.4	53.6	61.2	80.5	83.1
Numerator	103	112	170	572	798
Denominator	268	209	278	711	960
Data Source	CHCC RPMS and Childrens Clinic ASQ screening log	CHCC RPMS and Childrens Clinic Log	CHCC RPMS and Childrens Clinic Log	CHCC RPMS and Childrens Clinic Log	CHCC RPMS and Childrens Clinic Log
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Denominator value is based on the total number of children ages 6 months thru 71 months seen at the CHCC Children's Clinic for a well child visit in 2016. Numerator value is based on the total number of children ages 6 months thru 71 months seen at the CHCC Children's Clinic in 2016 who had an ASQ completed.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Denominator value is based on the total number of children ages 6 months thru 36 months seen at the CHCC Children's Clinic for a well child visit in 2017. Numerator value is based on the total number of children ages 6 months thru 36 months seen at the CHCC Children's Clinic for a well child visit in 2017 who had an ASQ completed. This measure was revised from the previous year (2016) as indicated in the change in age range being reported on. This change was made to align with the change in NPM 6 as well as so that it is aligned with the CHCC Developmental Screening policy in which ASQs are to be administered to children ages 6 through 36 months.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Denominator value based on the unduplicated number of children ages 6 months to 36 months who complete a well child visit at the CHCC Children's Clinic. The numerator value is the unduplicated number of children ages 6 months thru 36 months who completed and ASQ during a well child visit at the CHCC Children's Clinic.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Denominator value based on the unduplicated number of children ages 6 months to 36 months who complete a well child visit at the CHCC Children's Clinic. The numerator value is the unduplicated number of children ages 6 months thru 36 months who completed and ASQ during a well child visit at the CHCC Children's Clinic.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of children ages 6 through 36 months, who received a developmental screening using a parent-completed screening tool at Children's Clinic in the past year Denominator: Number of children who received a developmental screening using a parent-completed screening tool at Children's Clinic in the past year	

2016-2020: ESM 9.1 - Percent of schools that have implemented evidence based programs to address bullying.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		15	45	50	55
Annual Indicator	0	45	40	40	40
Numerator	0	9	8	8	8
Denominator	20	20	20	20	20
Data Source	CNMI Public School System	CNMI Public School System	CNMI Public School System	CNMI Public School System	CNMI Public School System
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data was gathered through a phone survey of all public schools in the CNMI.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data was gathered through a phone survey of all public schools in the CNMI.	

2016-2020: ESM 11.2 - Percentage of well-child clinics that receive training on care coordination.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			30	45
Annual Indicator			0	0
Numerator			0	0
Denominator			3	4
Data Source			MCH Program	MCH Program
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Programs that were identified to receive care coordination training include: Early Intervention (EI), Early Hearing Detection and Intervention (EHDI) and Children with Special Health Care Needs (CSHCN).	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Programs that were identified to receive care coordination training but was canceled include: Family to Family (F2F), Early Intervention (EI), Early Hearing Detection and Intervention (EHDI) and Children with Special Health Care Needs (CSHCN).	

2016-2020: ESM 13.2.1 - Percent of children from public elementary schools who receive dental sealants through the Public Health School Sealant Program.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		15	16	65	70
Annual Indicator	56.3	55.6	61.8	70.2	25.4
Numerator	814	813	910	987	355
Denominator	1,446	1,463	1,472	1,406	1,399
Data Source	Public Health Dental Clinic/Oral Health Prg	Public Health Dental Clinic/Oral Health Prg	Public Health Dental Clinic/Oral Health Prg	CHCC Dental Clinic/Oral Health Prg	CHCC Dental Clinic/Oral Health Prg
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Denominator value is based on the total number of 2nd and 6th grade students enrolled in CNMI Public Schools. Numerator value is based on the total number of 2nd and 6th students enrolled in public schools that receive dental sealants through the Public Health Dental Clinic School Sealant Program.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Denominator value is based on the total number of 2nd and 6th grade students enrolled in CNMI Public Schools. Numerator value is based on the total number of 2nd and 6th students enrolled in public schools that receive dental sealants through the Public Health Dental Clinic School Sealant Program.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Denominator value is based on the total number of 2nd and 6th grade students enrolled in CNMI Public Schools. Numerator value is based on the total number of 2nd and 6th students enrolled in public schools that receive dental sealants through the Public Health Dental Clinic School Sealant Program.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Denominator value is based on the total number of 2nd and 6th grade students enrolled in CNMI Public Schools. Numerator value is based on the total number of 2nd and 6th students enrolled in public schools that receive dental sealants through the Public Health Dental Clinic School Sealant Program.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Numerator: Number of children ages 1 through 17 who had preventive dental visit in the past year Denominator: Value is based on the total number of 2nd and 6th grade students enrolled in CNMI Public Schools.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Northern Mariana Islands

SPM 1 - Percent of deliveries to resident women receiving prenatal care beginning in the first trimester of pregnancy.
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Increase the number of resident women receiving prenatal care beginning in the first trimester
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of deliveries to resident women who received prenatal care beginning in the first trimester of pregnancy. **Denominator:** Total number of deliveries to resident women.
Data Sources and Data Issues:	CNMI Hospital records, CNMI HVSO data
Significance:	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.

SPM 2 - Percentage of health department (CHCC) staff that receive training on MCH priorities and/or related strategies.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	By 2025, increase the number of 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 training participants. **Denominator:** Number of health department (CHCC) employees.
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 Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of women of childbearing age screened for anemia.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	By 2020, reduce the rate of anemia in reproductive age women by 10%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of women ages 15 thru 44 years screened for anemia. **Denominator:** Total number of women ages 15 thru 44 years.
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 9.1: Reduce total preterm births. Related to MICH Objective 5: Reduce the rate of maternal mortality. Related to MICH Developmental Objective 16.1: Increase the proportion of women delivering a live birth who discussed preconception health with a health care worker prior to pregnancy.
Data Sources and Data Issues:	Hospital Records, CNMI HVSO data
Significance:	Iron deficiency in pregnant women increases the risk for a preterm delivery and low birth weight and subsequently could result in childhood anemia. In the CNMI, Iron deficiency coupled with low prenatal visit rates often time results in complications resulting in preterm births and requiring blood transfusions at delivery. Anemia screening will improve upon the identification, management, and reduction of complications related, including Severe Maternal Morbidity (SMM) and fetal and infant mortality. 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.

2016-2020: SPM 3 - Percent of children receiving routine vaccines.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of children ages 19 through 35 months that receive recommended vaccinations
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children ages 19 through 35 months who complete the combined 7-vaccine series (4:3:1:3:3:1:4) **Denominator:** Number of children ages 19 to 35 months
Healthy People 2020 Objective:	Related to Immunization and Infectious Diseases (IID) Objective 1: Reduce, eliminate, or maintain elimination of cases of vaccine preventable diseases. Related to IID Objective 7: Achieve and maintain effective vaccination coverage levels for universally recommended immunizations among young children.
Data Sources and Data Issues:	Hospital RPMS data system, CNMI Immunization Program data
Significance:	Immunizations are a pillar of child health care and one of the most effective ways to protect a child from serious, preventable diseases. However, according the CNMI MCH 2015 Needs Assessment, the overall coverage rates of immunization in CNMI is low at 73.5% in 2014. While the CNMI Immunization Program provides good coverage on vaccinations during vaccine campaigns such as the yearly influenza or the HPV vaccine, it is not adequately covering the child population.

2016-2020: SPM 4 - Percent of high school students that report thoughts of suicide.
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Decrease the rate of adolescent suicide ideation
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of high school students enrolled in Public School System grades 9th through 12th who report thoughts of suicide on the YRBS. **Denominator:** Number of students enrolled in Public School System grades 9th through 12th.
Healthy People 2020 Objective:	Related to Mental Health and Mental Disorders (MHMD) Objective 1: Reduce suicide rates
Data Sources and Data Issues:	Youth Risk Behavior Survey
Significance:	Nationally, thousands of people die by suicide every year. Many more attempt suicide but do not die. For every suicide death, there are approximately 3 hospitalizations for a suicide attempt, 10 emergency department visits for a suicide attempt, and 33 attempts that do not result in hospitalizations or emergency department visits. According to the National Youth Risk Behavior Survey, suicide thoughts and attempts are higher among high school students than among adults. In the Northern Mariana Islands, 39.8 percent of middle school students and 22.8 percent of high school students reported thoughts of suicide on the 2015 YRBS.

2016-2020: SPM 5 - Birth rate among 15-17 year olds
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Decrease teen births rates among 15-17 year olds
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** Total number of births among resident teen ages 15 to 17 years **Denominator:** Total number of female residents ages 15 to 17 years
Healthy People 2020 Objective:	Related to Family Planning (FP) Objective FP 7.1: Increase the proportion of sexually experienced females ages 15 to 44 years who received reproductive health services in the past 12 months Related to FP Objective 7.2: Increase the proportion of sexually experienced males ages 15 to 44 who received reproduction health services Related to FP Objective 8: Reduce pregnancies among adolescent females Related to FP Objective 12: Increase the proportion of adolescents who receive formal instruction on reproductive health topics before they were 18 years old
Data Sources and Data Issues:	CHCC Hospital Records, CNMI HVSO data
Significance:	Teen births increase health risks to both mother and child including low birth weight, preterm birth, and death in infancy. In addition to health risks, teen births set up a cycle of disadvantages. Teen mothers are less likely to finish high school and their children are more likely to have low school achievement, drop out of high school, and give birth themselves as teens. According to the 2015 CNMI MCH Needs assessment, The CNMI teen birth rate for 2013 was 27.7 births per 1,000 females, which was more than double the national rate.

2016-2020: SPM 6 - Percent of resident children, ages 0 thru 17 years, seen at any CHCC site with health insurance coverage.
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of children who have continuous health insurance coverage.</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 children, ages 0 thru 17 years, seen at CHCC with continuous health insurance coverage.</td></tr>
<tr><td>Denominator:</td><td>Number of children, ages 0 thru 17 years seen at CHCC.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be obtained through the CNMI CHCC RPMS Data System.</td></tr>
<tr><td>Significance:</td><td>Not having insurance or the financial means to pay for medical care is one of the most cited barriers too accessing preventive care for many individuals and families in the CNMI. If children are continuously insured, parents are more likely to seek preventive services for their children.</td></tr>
</table>

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 who report an increase in access to preventive services.
NPM 1 – Percent of women, ages 18 through 44, 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 increase the number of women accessing preventive health services by expanding clinic hours.</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 women surveyed who report increase access to preventive health services.</td></tr>
<tr><td>Denominator:</td><td>Number of women surveyed.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data source will be a survey of women who visit the health department/CHCC clinics.</td></tr>
<tr><td>Significance:</td><td>Evidence suggests that expanded hours increases access and provides opportunities for working women and others with schedule challenges to access care.</td></tr>
</table>

ESM 4.1 - Percentage of workplace presentation participants who report increase in knowledge and skills regarding workplace breastfeeding policies.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of workplace presentations and workplace policies implemented to support breastfeeding mothers.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of workplace presentation participants surveyed who report increase in knowledge and skills regarding workplace breastfeeding policies. **Denominator:** Number of workplace presentation participants surveyed.
Data Sources and Data Issues:	The MCH program will develop a survey to gather data for this measure.
Significance:	Support for breastfeeding mothers in the workplace through workplace policies on breastfeeding is critical for women to sustain breastfeeding their infants at least till 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.

ESM 8.1.1 - Percentage of 6- 11 year old children accessing well-child visits who report being physically active at least 60 minutes per day.
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 the number of children ages 6 through 11 years are physically active at least 60 minutes per day through accessing obesity prevention interventions and education during well-child visits.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 6- 11 year old children accessing well-child visits who report being physically active at least 60 minutes per day. **Denominator:** Number of 6-11 year old children accessing well-child visits.
Data Sources and Data Issues:	Data will be gathered through the CHCC Electronic Health Records System (EHR) and a survey of parents whose children accessed well-child visits.
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 is an important place to address obesity prevention given the influential role of pediatric primary care providers and their regular contact with families during well-child visits.

ESM 10.1 - Percentage of adolescents accessing preventive care who report being referred by their school.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	The goal is to increase the number of adolescents accessing annual visits by partnering with the public school system to facilitate referrals.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents accessing preventive care who report being referred by their school. **Denominator:** Number of adolescents accessing preventive care.
Data Sources and Data Issues:	Data will be collected via a survey instrument.
Significance:	The adolescent well-visit is an opportunity for adolescents to receive healthcare, counseling, and guidance to help teens identify and adopt or modify behaviors to avoid damage to health, effectively manage chronic conditions, or to prevent disease. Adolescent healthcare is critical for establishing lifelong healthy behaviors and prepares adolescents for transition into adult healthcare.

ESM 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.
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 students and/or parents who indicate increased knowledge about the importance of transition after presentations.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	The goal is to utilize school based presentations to increase awareness and knowledge regarding the importance of and process of transition into adult healthcare.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of students and/or parents who indicate increased knowledge about the importance of transition after presentations. **Denominator:** Number of students and/or parents who attend transition presentations.
Data Sources and Data Issues:	A survey instrument will be utilized to collect data for report on this measure.
Significance:	Healthcare transition is defined by the American National Alliance to advance adolescents healthcare as the process of changing from a pediatric to an adult model of health care. This is critical for ensuring continuity of care and prioritization of key factors for health improvement. The benefits of transition include preparing the adolescent early for taking responsibility for his care by knowing his own condition, progress, medications and possible disease outcome.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Percent of women ages 18 thru 44 seen at mobile clinic outreach events.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	By 2020, increase the number of women who a complete a preventive visit by 10%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women ages 18 through 44 that are seen during a mobile clinic outreach event. **Denominator:** Number of women ages 18 through 44
Data Sources and Data Issues:	CHCC RPMS, Electronic Health Record, US Census International Database Population Estimator
Significance:	Increasing the amount of sites that offer preventive services throughout the CNMI is a strategy towards eliminating barriers to accessing care. Many families in the CNMI either do not own vehicles or face difficulty purchasing fuel. Fuel costs in the CNMI is among the highest in the nation peaking at almost $5.30 per gallon. The CNMI also lacks a fully functioning public transportation system. Bringing the services to clients through the use of non- traditional sites, youth and village centers, other partner program offices, or through the use of a mobile clinic will help to increase the number of women that obtain preventive care.

2016-2020: ESM 1.2 - Percent of women ages 18 thru 44 seen at the Family Planning Program.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2020, to increase the number of women who complete a preventive health screening by 10%.</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 women ages 18 thru 44 seen by the Family Planning Program.</td></tr>
<tr><td>Denominator:</td><td>Number of women ages 18 thru 44.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CHCC RPMS</td></tr>
<tr><td>Significance:</td><td>Integrating preventive services within the context of the family planning visit is listed as a recommendation by CDC not only for improving the delivery of quality family planning services, but to improve overall health outcomes for women, men, and their children.</td></tr>
</table>

2016-2020: ESM 4.2 - Percent of infants enrolled in Home Visiting breastfed through 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:	By 2020, increase the percent of mothers reporting exclusive breastfeeding by 10%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 6 month old infants enrolled in Home Visiting breastfed through 6 months. **Denominator:** Number of 6 month old infants enrolled in Home Visiting.
Data Sources and Data Issues:	MIECHV Home Visiting Efforts to Outcomes Data System
Significance:	MCH will work to improve infant/perinatal health outcomes by promoting early and adequate prenatal care services and promoting breastfeeding and safe sleep. Breast milk is the natural first food for babies, provides all the nutrients that infants need, and is linked to many positive health outcomes for both mother and baby. Studies have shown that breast milk promotes sensory and cognitive development and protects against infectious and chronic diseases.

2016-2020: ESM 6.1 - Percent of children who complete an ASQ screening at the CHCC Children's Clinic during a well-child visit.
2016-2020: NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	By 2020, increase the proportion of young children who are screened, evaluated, and enrolled in special services in a timely manner fro baseline to 25%, 5% each year.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of children ages 6 months thru 36 months seen at the CHCC Children's Clinic for a Well Child visit who had an ASQ completed.</td></tr><tr><td>**Denominator:**</td><td>Number of children ages 6 months thru 36 months seen at the CHCC Children's Clinic for a Well Child visit.</td></tr></table>
Data Sources and Data Issues:	CHCC RPMS, Electronic Health Record (EHR), CHCC Children's Clinic ASQ Screening log.
Significance:	Developmental screening is critical to the early identification of developmental delays and the provision of early intervention services that could improve both short and long-term developmental outcomes of children who may be experiencing delays or have a developmental disability.

2016-2020: ESM 9.1 - Percent of schools that have implemented evidence based programs to address bullying.
2016-2020: NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	By 2020, reduce the number of students who report being bullied at school by 10%.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of schools within the CNMI Public School System that have implemented evidenced based programs to address bullying.</td></tr><tr><td>**Denominator:**</td><td>Number of schools within the CNMI Public School System.</td></tr></table>
Data Sources and Data Issues:	CNMI Public School System administrative records, Program Records
Significance:	Studies show that bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Those who bully others tend to exhibit defiant and delinquent behaviors, have poor school performance, more likely to drop- out of school, and more likely to bring weapons to school. Victims report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation, and suicide attempts. According to the 2015 CNMI YRBS, 58.5% of middle school students and 22.1% of high school students surveyed reported being bullied in school.

2016-2020: ESM 11.2 - Percentage of well-child clinics that receive training on care coordination.
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:	To increase the number of well-child clinics throughout the CNMI that receive training on the care coordination- a component of the medical home model.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of clinics that have staff completing training on care coordination **Denominator:** Number of well-child clinics
Data Sources and Data Issues:	MCH Program Records, Sign-in Sheets
Significance:	As a component of the Medical Home Model, the AAP describes care coordination as "an essential element of a transformed American health care delivery system that emphasizes optimal quality and cost outcomes, addresses family-centered care, and calls for partnership across various settings and communities. High-quality, cost-effective health care requires that the delivery system include elements for the provision of services supporting the coordination of care across settings and professionals."

2016-2020: ESM 13.2.1 - Percent of children from public elementary schools who receive dental sealants through the Public Health School Sealant Program.
2016-2020: NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	By 2020, increase the percentage of children ages 1 through 17 years old who had a preventive dental visit by 10%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 2nd and 6th grade public school students who receive dental sealants. **Denominator:** Number of children enrolled in 2nd and 6th grade students enrolled in the Public School System.
Data Sources and Data Issues:	CHCC RPMS
Significance:	Studies have shown that poor oral health in children can result in adverse school performance and their success later in life. Children with poor oral health suffer from persistent dental pain, endurance of dental abscesses, inability to chew foods, embarrassment, and distraction from play and learning.

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 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Quarterly	3		
2) Vital Records Death	Yes	Yes	Annually	12	Yes	
3) Medicaid	Yes	Yes	Monthly	12	No	
4) WIC	Yes	Yes	Annually	12	No	
5) Newborn Bloodspot Screening	Yes	Yes	Monthly	1	No	
6) Newborn Hearing Screening	Yes	Yes	Monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Monthly	1	No	
8) PRAMS or PRAMS-like	No	No	Never	NA	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Developmental Screening	Yes	Yes	Monthly	1	No	
10) Immunization Information System	Yes	Yes	Daily	1	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None