

**Maternal and Child  
Health Services Title V  
Block Grant**

**Northern Mariana Islands**

**FY 2016 Application/  
FY 2014 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



July 3, 2015

Subject: 2015 Title V Block Grant

To Whom It May Concern:

The Commonwealth of the Northern Mariana Islands' Commonwealth Healthcare Corporation (CNMI-CHCC) submits its response herein to the U.S. Department of Health and Human Services and Maternal & Child Health Services Title V MCH Block Grant funding opportunity. The CNMI will continue to use Title V MCH Block Grant funds to provide preventive and primary health care services to mothers, pregnant women, infants, children, adolescents, and children with special health care needs. The CNMI selected eight priority needs based on the needs assessment survey conducted over a period of five years.

The 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 across the life course, 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 Board and the key stakeholders in the community. The final priorities across the six domains for the CNMI are: 1) improve women's health through cervical and breast cancer and anemia screening; 2) improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep; 3) improve child health through providing vaccinations and screening for developmental delays; 4) improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide); 5) provide a medical home for children identified as CSHCN; 6) improve early identification of CSHCN through screening for developmental delays; 7) improve oral health of children and; 8) improve insurance status of children and pregnant mothers.

The goal of our proposed initiative is to provide our MCH population with a seamless health care system by increasing access, availability, effectiveness and participation to evidence-based programs that will promote a system to help foster optimal health and well-being.

Thank you,

A handwritten signature in black ink, appearing to read "Esther L. Muna".

Esther L. Muna  
CHCC Chief Executive Officer

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P.O. Box 500409 CK, Saipan, MP 96950  
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## **I.B. Face Sheet**

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

## **I.C. Assurances and Certifications**

The State certifies assurances and certifications, as specified in Appendix C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

## **I.E. Application/Annual Report Executive Summary**

The mission of the Maternal and Child Health (MCH) Bureau 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 MCH Bureau, under the Commonwealth Healthcare Corporation (CHCC), manages the MCH Program, Early Childhood Comprehensive Systems Project, Healthy Outcomes for Maternal and Early Childhood (H.O.M.E.) Visiting Program, Family Planning Program, Early Hearing and Detection Intervention Program, Children with Special Healthcare Needs Program, Oral Health- Teeth for Health Initiative, and State Systems Development Initiative Project. The MCH Program directs the priorities of the Title V Block Grant resources.

The MCH Program conducted a community and stakeholder driven programmatic Needs Assessment (NA) of services provided to mothers and children in the CNMI. The NA served as an essential tool to direct focus on system changes and examine the health status of CNMI's families. Although there have been improvements in some areas, there continue to be disparities based on race, income, age, insurance coverage and geographical area which still present challenges. The NA was guided by the life-course theory framework, which looks at other factors that contribute to the health of families across the life course. Based on this assessment, the following MCH priorities were identified and will provide guidance for MCH related activities and funding during FY 2016 – FY 2020.

### **PRIORITIES**

Women's/Maternal Health- Improve women's health through cervical and breast cancer and anemia screening.

Perinatal/Infant Health- Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep

Child Health- Improve child health through providing vaccinations and screening for developmental delays.

Adolescent Health- Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).

CSHCN-Provide a medical home for children identified as CSHCN; Improve identification through screening for development delays.

Cross Cutting-Improve oral health for children and pregnant women; Improve insurance status of children and pregnant mothers.

During the NA, stakeholders identified emergent needs of the CNMI MCH population. The following list shows the National Performance Measures (NPMs) selected by the CNMI MCH Program. State Performance Measures were also developed to address the priorities not related to the NPMs. Evidence-based strategies will be developed to ensure the program meets the required measures.

National Performance Measure Selected by CNMI:

NPM 1 – Percent of women with past year preventive medical visit. (Pap & Mammogram)

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

NPM 5 – Percent of infants placed to sleep on their backs.

NPM 6 – Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool.

NPM 9 – Percent of adolescents, ages 12-17, who are bullied or who bully others.

NPM 11 – Percent of children with and without special health care needs having a medical home.

NPM 13 – A. Percent of women who had a dental visit during pregnancy B. Percent of children, ages 1-17, who had a preventive dental visit in the past year.

NPM 15- Adequate insurance coverage (Percent of children ages 0 through 17 who are adequately insured).

As part of efforts to address the evolving issues of the MCH population, the MCH Program and partners developed the following state performance measures to address aforementioned priorities:

Increase women screened for anemia

Increase early and adequate prenatal care- women receiving prenatal care beginning in first trimester stratified by insurance

Increase children receiving routine vaccines

Decrease adolescent suicide

Decrease teen pregnancy rates among 13-17 year olds

## **ACCOMPLISHMENTS & PLANS**

The convergence of MCH programs into an organized Bureau was one of the main accomplishments to improve service coordination. Key personnel required to address challenges were recruited- MCH Epidemiologist, Services Coordinator and CSHCN Coordinator.

Women/Maternal Health: Of the 14,522 women of childbearing age in the CNMI, only 1% had a non-prenatal visit at the CHCC in 2014. Only 30% of pregnant women received adequate prenatal care in 2013. Activities to address these alarming rates included the recruitment of a MCH Services Coordinator to provide presumptive eligibility for Medicaid MCH clients and enhance case management of high-risk pregnancies. The OB/GYN Department Chair, also a MCH advisor, conducted an evaluation of clinic services and participated in an initiative aimed at improving services at CHCC Women's Clinic. Quality assurance and performance improvement measures were established in response to the evaluation, which included patient input. Other activities included updating the MOU with the Medicaid Office to include data sharing services, the allowance of MCHB to receive, review, and submit MCH client's application for processing, and to expedite the processing of MCH applications. Educational campaigns targeting women included local TV and movie theater commercials, local media advertisements, poster distributions, and social media posts (Facebook and Twitter accounts).

In FY 2016, evidence based strategies based on a life course perspective include:

- Increase awareness of preconception health
- Increase awareness of the importance of having a reproductive plan
- Advocate for health insurance coverage and improvements
- Establishing baseline data for new priorities (anemia screenings, etc.)
- Improving partnership with breast and cervical screening services
- Improving access to services (mobile clinic, outlying clinic in at-risk area, etc.)

Perinatal/Infant Health: In 2012, the infant mortality rate increased to 0.8. In 2013, it reached CNMI's highest rate for the past five years of 1.0. In review of leading causes of infant mortality for 2009 through July 2014, 91% of the infant deaths were attributed to serious birth complications including prematurity, respiratory failure and cardiorespiratory arrest. As such, the Infant Mortality CollN to Reduce Infant Mortality was implemented. Select members of the CNMI CollN Team took part in the August 2014 Region IX Pacific Basin Infant Mortality CollN Expansion Summit in order to glean strategies to reduce infant mortality and address the key contributors to infant mortality. A CNMI Fetal and Infant Mortality Review committee was formed comprised of key MCHB staff along with internal and external partners. Planned activities include the recruitment of a family representative and a private provider.

To improve perinatal/infant outcomes the following are strategies to address this priority in FY 2016:

- Promote early and adequate prenatal care
- Partner with H.O.M.E. Visiting Program to improve breastfeeding and safe sleep practices
- Improve access to prenatal care services through the use of mobile clinic, extension of sites, and health coverage assistance
- Enhance data collection with CNMI CollN Team
- Engage providers in breastfeeding and safe sleep strategies

Child Health: In 2013, only 55.3 percent of children age 19 to 35 months received the recommended vaccinations. In 2014, the MCHB Early Childhood Comprehensive Systems Project implemented for the first time a standard screening tool for developmental delays for all children receiving services at CHCC. Furthermore, through a collaboration with the Child Care Developmental Fund, the Ages and Stages Questionnaire (ASQ)-3 developmental screening training is now administered at eligible daycare centers. The newly hired CSHCN Coordinator is also trained to conduct ASQ-3 trainings for providers and parents. Plans for 2016 include, but will not be limited to priority areas selected to improve child health through:

- Supporting providers to integrate developmental screenings as a part of routine care
- Implementing a social emotional standard screening tool
- Implementing the Well Child module in the CHCC Electronic Health Records
- Increasing immunization rates by aligning and strengthening program efforts with CHCC Immunization Program
- Disseminating child health data to community partners
- Improving health services provided to children by advocating to eliminate barriers such as health coverage and geographical disparities (i.e. no pediatric services in outer islands of Rota and Tinian)
- Improving injury prevention education to the community
- Partner with H.O.M.E. Visiting Program and Community Guidance to increase awareness of adverse childhood experiences in the community

Adolescent Health: The NA highlighted numerous areas of improvement for this domain. When the CHCC became a semi-autonomous agency in 2012, limited transition funding from the central government resulted in the closure of outlying clinics, such as the school-based Adolescent Health Clinic and wellness centers where adolescents were frequently accessing critical services. In 2013, the teen pregnancy rate increased to 27.7 from 16.3. In 2014, the Family Planning program funding was suspended. In 2015, the MCH Bureau applied for new funding for family planning services and was awarded. The MCH and Family Programs will collaborate to facilitate the mobile clinic preventative and health outreach services to schools and villages.

Planned activities for 2016 to improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide) include the following strategies:

- Establish a school-based Adolescent Health Program to improve adolescent health services and reduce risk behavior
- Improve access to adolescent health services
- Disseminate adolescent health data to community partners
- Establish relevant campaign strategies to engage public in addressing areas of improvement for this group

Children with Special Health Care Needs (CSHCN): In the past five years, services provided for CSHCN were through a collaboration with the Public School System, Early Intervention Services for infants, 0-3 years old. Also, through a partnership with Shriners Hospital of Hawaii specialty services in Cardiology, EENT, Orthopedics, and selected surgeries are available at least once a year. It is important to note that there is limited to no services, based on specialty, available for this population so families are often referred off island for extended periods. Case management of this vulnerable group was a challenge due to the absence of a system to identify and track CSHCN. MCHB Early Hearing Detection and Intervention Program also contracts to provide ongoing services of an Audiologist.

The transition of the CHCC out of the central government, provided challenges, included the suspension of critical services that address the needs of families with CSHCN. The CHCC Newborn Screening Program was suspended. The MCH Program lost the ability to track infants born with birth defects when the Health and Vital Statistics Office was restructured. To address these challenges the MCH Program submitted a proposal to continue State Systems Development Initiative funds to improve and explore long term data related strategies. The recruitment of the MCH Epidemiologist and Data Analyst were major accomplishments for the CNMI's data infrastructure. Additionally, the Newborn Screening/Family Support and CSHCN Coordinators were recruited to expand and enhance CSHCN programs. A database was also developed to track all children from birth to 21 years of age with special needs.

In 2016, strategies to improve identification of CSHCN through screening for developmental delay will include:

- Support providers to include development screenings as a part of routine care
- Ensure modification and linkage of the CSHCN database with CHCC's EHR and RPMS
- Begin case management of CSCHN from birth to 21 years old
- Link families to medical homes and community resources

Cross-Cutting: Dental caries remain one of the most unmet needs for children in the CNMI. During school year 2014-2015, 66% of all students screened through the Head Start Fluoride Varnish Program had dental caries. The CHCC dental clinic is the only clinic serving Medicaid beneficiaries and the uninsured. The needs assessment process also involved the review of oral cancers in the CNMI as increasing fatalities due to oral cancers have heightened the

community's attention to the health risks associated with chewing betel nut and overall poor oral health.

Competing priorities in 2012 resulted in the closure of the CHCC dental clinic. Under the guidance of the MCH Program, a proposal to improve oral health was written and awarded. In 2014, the CNMI applied for the renewal of federal funds supporting the Oral Health Program. To address the priority to improve oral health of children and pregnant mothers, in 2016 the MCH Program will continue to collaborate with the Oral Health- Teeth for Health Initiative to align program efforts and utilize these strategies to address this priority:

- Support providers to integrate oral health screenings for children and pregnant mothers as part of routine visits
- Advocate for dental health coverage
- Improve access to dental health services for outer islands
- Establish baseline data for betel nut chewing among children and pregnant mothers
- Develop data systems to track and report betel nut chewing

Cross-Cutting: Insurance status of children and pregnant mothers is the number one barrier to receipt of health services. In 2013, half of all children living the CNMI and 25% of women utilizing medical care at CHCC were uninsured. In 2014, the MCH Program collaborated with the Medicaid Program to provide presumptive eligibility services for the MCH population in the community. A referral system was established within programs in MCH Bureau. For instance, H.O.M.E. Visiting Program enrolled families are referred to MCH Services Coordinator who provides Medicaid and CHCC Sliding Scale Fee eligibility assistance. At least once a week, the process is finalized by having the MCH Services Coordinator visit the Medicaid Office to complete applications. The MCH Program intends to seek guidance and work collaboratively with the CNMI government to address this priority.

Other strategies for 2016 include:

- Improve access to insurance coverage by increasing community awareness of eligibility and application requirements including Medicaid
- Improve access to Medicaid coverage by decreasing application processing time
- Establish an evaluation and tracking system for insurance status

## **II. Components of the Application/Annual Report**

### **II.A. 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. According to the United States Census Bureau, the total population in CNMI is 53,883; a decrease of 22 percent from the 2000 Census. 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 CNMI population is categorized into three segments: local, other Micronesians, and foreign contract workers. Local residents are primarily Chamorro with smaller groups of Carolinians; these are the two ethnic groups indigenous to the CNMI. Micronesians include other island ethnic groups, such as Palauan and Chuukese. The U.S. "Compacts of Free Association" permits the free movement of people between the freely associated states, flag territories, Hawaii and the U.S. mainland. These "Compact" islands include the Republic of Palau; the Republic of the Marshall Islands; and the islands comprising the Federated States of Micronesia, Kosrae, Chuuk, Pohnpei, and Yap. Foreign contract workers from Asia (primarily Chinese and Filipino) comprise over half of the CNMI's population. These contract laborers work in CNMI's private and public sector in difficult-to-fill positions. While the CNMI originally maintained control over its own labor and immigration regulation and enforcement, recent federal legislation has mandated a federalization of labor and immigration. Federalization of the CNMI immigration system, which began in June 2009, is expected to significantly decrease the number of foreign workers in the CNMI. The median age of the population in CNMI is 28.7 years old, which is higher than other islands in the Pacific region. This is in part due to a high number of foreign contract workers who are usually between 18 and 44 years old.

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 now 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 is also administered by CHCC. The Chief Executive Officer of CHCC is the authorized representative for the CNMI MCH Title V Program. There are three divisions under the corporation: 1) Public Health -- provides preventive and community health programs in which many are federally funded; 2) Hospital; and 3) Community Guidance Center. The Director of Public Health Services also provides oversight to all the public health programs, including the MCH Title V Program.

Besides the hospital, the CHCC also operates several outpatient facilities, providing an estimated 80 percent of all outpatient health care in the CNMI. Several clinics are physically located at the hospital, including the adult clinics (providing internal medicine, surgery and orthopedics services), hemodialysis unit, a women's clinic focusing on obstetric and gynecologic care, a pediatric clinic for children from birth to age 16, and a walk-in acute-care clinic. There are five private outpatient clinics along with peripheral clinics on the islands of Tinian and Rota. Homecare nursing services are available through two private sector agencies.

### **Healthcare for the CNMI MCH Population**

The MCH Title V Program is administered by the CHCC Division of Public Health Services (DPHS), within the newly formed Maternal and Child Health Bureau. 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; Kagman Community Health Center – located in the village of Kagman; and Rota and Tinian Health Centers- located in the outer islands. MCH services 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 test, hypertension, blood sugar, developmental screenings for infants and children, newborn hearing, and oral health screenings.

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 DPHS. 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) and a medically underserved area. In line with the Division of Public Health's mission statement: "To achieve optimal health and well-being of the NMI through protection, promotion, and prevention of disease in partnership with the community", the MCH Program continues to support and enhance the provision of preventive and primary health care services.

Services for Pregnant Women, Mothers, Infants: The Women's and Children's Clinic located at Commonwealth Healthcare Center (CHCC) provides comprehensive primary and preventive services for MCH target group. As of July 2015, there are four OB/GYN working at the Women's Clinic in addition to 2 mid-level providers. There are six (6) pediatricians at the Children's Clinic. Limited services are also provided at Rota and Tinian Health Centers for patients residing in the outer islands. The MCH Program enables services at both clinics such as case management of high risk patients, development of educational materials including posters and brochures, and staff to assist with developmental screenings and health coverage applications.

The establishment of the Kagman Community Health Center, a federally qualified health center, in 2012 located in one of the remote villages in the northeast part of Saipan has improved access to healthcare services for the MCH population. The CNMI MCH Bureau intends to be instrumental in the establishment of a community health center in the southern part of the island.

Services for Children and Adolescent- Health care services for children and adolescents are provided at the Children's Clinic. Dental health services are also provided at CHCC. Again, MCH Program provides enabling services such as transportation, translation, referrals, incentives, and educational materials. Through ECCS and home visiting initiatives, the MCH Program help families navigate through state programs. Majority of families seek assistance for WIC, Food Stamps, and Medicaid. As previously stated, MCH Program plans to address barriers to health services for all MCH groups in the CNMI. The utilization of a mobile clinic and expansion of clinical sites offering primary and public health services are planned strategies to improving services for 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 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 Cardiology, Audiology, ENT, and selected surgeries. The implementation of the ASQ screening tool at the early intervention services program, daycare centers, and the CHCC Children's Clinic has increased the referral of babies screened for developmental delays. Improving case management of CSHCN in addition to having access to specialties off-island are both strategies the MCH Program will utilize in the coming years.

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 majority of clients are not eligible for Medicaid and even

those that are may not be willing to stand in line and then wait weeks for the time it takes to place an application and get a response. 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. As stated in the Needs Assessment findings, seeking preventive services or paying for health insurance premiums is not a priority for families in the CNMI. Poverty and other competing factors impede the health of many families in the CNMI. The 2010 Census reports 50% of families live below the poverty level. Therefore, the community tends to seek health care for acute situations and severe conditions only when they cannot avoid it – a process that most often leads to poor outcomes and expensive specialty care.

### **CNMI Health Priorities for 2016 to 2020**

The CNMI selected the final eight priorities based on the needs assessment finding. In collaboration with partners, including leaders in community, educators, health providers, and other key community professionals/members, ongoing activities to address priorities include:

#### **Improve women’s health through cervical and breast cancer and anemia screening.**

Preventive care are not readily accessed by CNMI women. In 2013, only 33 percent of pregnant women received adequate prenatal care. Moreover, only 1,534 women had non-prenatal visits at CHCC. The MCH Program will work closely with CHCC management and partners, such a Women, Infants, and Children’s (WIC) and Breast and Cervical Screening Programs to expand services into the villages and other non-traditional settings. Services will be provided locally, in all three inhabited islands, and include Centering Pregnancy/Centering Parenting care. Preventive care provided by the Mobile Clinic which will be on site at regularly scheduled intervals. The Mobile Clinic will provide preventive care and preconception health using collaborating services such as Title X Family Planning to provide reproductive life screening and planning, Breast and Cervical Screening Program for pap and mammogram screenings, WIC services for nutrition, and other partners as indicated. Visits will be entered into the RPMS Electronic Health Record (EHR) which has a built in case management program (iCare) that allows formation of panels of patients in order to track and monitor care. Education and information will be provided about available preventive services and participants will be encouraged to bring other household or family members for care. Other activities included patient referrals at outreach activities, home visits, and other sources. The MCH Program will lead the establishment community health center in the southern part of the island, which will offer primary and preventative health services for CNMI families.

#### **Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep.**

Each year approximately 1,000 babies are born in the CNMI. Infant/perinatal mortality rates continued to increase between 2010 and 2014. In 2014, only 33 percent of infants were born to mothers with adequate prenatal care. The MCH Program will partner with key stakeholders to address this priority. Promoting breastfeeding and safe sleep for families receiving home visiting services will be one of the strategies used. Services/initiative below will continue:

-Build capacity of CNMI CoIIN Team; The CNMI participated in the Region IX Pacific Basin Infant Mortality CoIIN Expansion Summit in order to glean CoIIN strategies to reduce infant mortality and address the key contributors to our Commonwealth’s infant mortality based on the five year data (2009-2013) put together by the recently established CNMI Fetal and Infant Mortality Review (FIMR) committee. The CNMI CoIIN Team is comprised of multidisciplinary members. The MCH Program will continue to share health expertise, training, and data infrastructure

to support this initiative.

-Group Prenatal Care/Case management of high-risk pregnancies: One of the strengths of the MCH Program is that the main partner in reducing health disparities for the CNMI maternal population is the Chief of OB/GYN, Dr. Jeanolivia Grant. Dr. Grant is one of four providers at the Women's Clinic administering the case management of our high-risk mothers. The launch of the first ever Group Prenatal Care was held during the 1<sup>st</sup> Annual CNMI Women's Health Month. The MCH Program will lead the coordination of this initiative in collaboration with CHCC providers and WIC Clinic. Additionally, MCH will assist in the implementation of case management module in the Electronic Health Record (EHR).

-Breastfeeding at Hospital Discharge: In collaboration with partners at WIC, the recruitment of an IBCL consultant was completed and training on breastfeeding support was provided to CHCC nurses, H.O.M.E Visiting staff, and other key staff.

### **Improve child health through providing vaccinations and screening for developmental delays.**

The MCH Program works closely with community partners and providers at CHCC to improve overall health of children in the CNMI. A pediatrician serves on the CNMI CoLIN Team and is also a member of the MCH Advisory Board. The Early Childhood Comprehensive Systems (ECCS) Project implemented a standard screening tool for developmental delays at CHCC clinics and eligible centers. The MCH Program will partner with ECCS and CHCC to implement the Well Child software in the Electronic Health Record. This system will be used to establish baseline data for developmental screenings in the CNMI. Further, the MCH Program will partner with the CHCC Immunization Program to improve the overall coverage rates of immunization in CNMI which was at 73.5% in 2014, The Immunization Program provides ample coverage on vaccinations during vaccine campaigns such as the yearly flu vaccine or the HPV vaccine, but is not adequately covering the child population. CNMI MCH Program plans to improve immunizations through education and outreach and promotion of vaccinations during well baby clinic visits.

### **Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).**

In collaboration with the Public School System (PSS), a PSS/CHCC Partnership Committee was formed in an effort to provide continuous participation between the two agencies in addressing the needs of children and adolescents. The MCH Program will establish an Adolescent School Health Program which will focus on prevention, including health, bullying, substance abuse, and other factors relative to meeting this priority. There are plans to collaborate with Dinanña' Manhobin, Teen Talk Live Group, and the Let's Move Marianas Alliance to conduct outreach activities on Saipan, Tinian, and Rota. The CNMI Teen Talk Live Group and MCH Program will be the lead in addressing adolescent risk behaviors in all public and private schools.

### **Provide a medical home for children identified as Children with Special Health Care Needs.**

Although the CNMI has made significant advances in meeting the health of Children with Special Healthcare Needs, the case management of this vulnerable group has been a major gap in meeting the core outcomes of this population. In 2013, only 46 percent of CSHCN received coordinated, ongoing, comprehensive care within a medical home. The MCH Program has already recruited a CSHCN Coordinator who will work to establish a tracking system to identify CSHCN from birth to 21 years of age.

#### *Improve identification of CSHCN through screening for developmental delays.*

The MCH CSHCN Coordinator and the Health Analyst will continue to collaborate with the PSS Early Intervention Service to provide service coordination to an average of about 80 families per month with special needs children. The CSHCN Coordinator, Ms. Annmarie Satur, also assisted with the planning and implementation of the ASQ-3 developmental screening tool at all licensed daycares and the Children's Clinic.

### *Improve oral health of children and pregnant women.*

The Oral Health Project, managed within the MCH Bureau, met many milestones including the short-term hiring of dentists that enabled the reopening of the only public dental clinic in the CNMI. Another major accomplishment was the recruitment of a permanent dentist, Dr. Adam Gentry, on June 1, 2014. Prior to Dr. Gentry's appointment, the short-term recruitment of two other dentists allowed for the program to conduct preventative and curative dental services during the latter part of 2013. The successful hiring of both short-term and permanent dentists allowed the program to continue its Fluoride Varnish Application Program at the Children's Clinic, WIC, Headstart Centers, Daycare Centers, and other outreach events. The MCH Program will work closely with the Oral Health Program to improve oral health services for children and pregnant women.

### **Improve insurance status of children and pregnant mothers.**

Barriers to access to health care services are lack of transportation, including public transportation, lack of financial resources, immigration status, and lack of health insurance –although there are many that are enrolled in the Medicaid program that do not access preventive screenings. Due to high premium rates for private health insurance, others listed as uninsured are left with a choice to meet daily cost of living or decline health coverage. There are also other competing factors in the family's life that does not allow them to access care, especially health care services such as unemployment. Research has that socioeconomic characteristics and the availability of resources influence health behaviors including getting preventive health screenings. The MCH Program will advocate for health coverage for children and pregnant mothers. Key strategies include reviewing the current CNMI State Medicaid Plan to eliminate the cap on CHIP funding, providing presumptive eligibility services in collaboration with Medicaid and other partners, and assisting families with the CHCC Sliding Scale Fee application.

### **Health Care Reform Efforts**

As part of the ACA, expansion funds were allocated to the CNMI Medicaid Office. However in August 2014, the Department of Health and Human Services (HHS) determined that the ACA does not apply to the US territories including the CNMI. Therefore, at this time The CNMI does not know if Medicaid will be able to continue expanding services past 2019 when the first round of ACA funding will expire.

### **Process Utilized to Identify Factors Impacting Health Services**

The partnership the program has with health providers continues to be one of the major successes in meeting the priorities of the MCH population. Some of the main objectives to identify factors impacting health services for the MCH population have been to update baseline data, conduct priority ranking survey, and incorporate lifecourse metrics into systems of care. In preparation for the 2015 Needs Assessment, the MCH Program partnered with the Kagman Community Health Center (KCHC) to conduct a community needs assessment survey. The MCH Program Coordinator also serves on numerous committees, councils, and community groups to solicit input from key stakeholders including family consumers/partners.

During 2014, the MCH Needs Assessment Steering Committee met regularly to set priorities, update surveys, analyze data and trends, and to prepare for Needs Assessment. The hiring of an expert consultant was procured through a competitive process to review Needs Assessment findings. Due to other competing priorities and deadlines, the hiring of a consultant was delayed and finally completed in 2015. However, the MCH Program Coordinator and other key staff conducted focus groups and partnership meetings to solicit input on the Needs Assessment process. The MCH Needs Assessment Advisory Committee from external and internal stakeholders was also formed in 2014.

### **Current and Emerging Issues**

The Needs Assessment process involved a community wide survey of services provided for the MCH population. Focus groups were also conducted to solicit input from different target groups including high school students,

incarcerated women, families with one more infant losses, H.O.M.E. visiting families, and families with children with special needs. Further, during the month of May (CNMI Women's Health Month), a Breakfast Club was formed by the MCH Program. This club consists of women of prestigious backgrounds including a judge, former House Representative, health providers, the Chief Executive Officer of CHCC, a licensed counselor, social worker, and so forth. The results of the Needs Assessment highlighted emerging issues in CNMI -teen dating violence, use of non-illicit drugs among high school students, cyber bullying, betel nut chewing among pregnant women and younger groups, lack of health services for incarcerated women, and teen pregnancy. Adverse Childhood Experiences (ACEs) contribute to overall poor health outcomes for children- dental caries/childhood obesity high at schools visited, healthcare coverage for middle class, non-identification of CSHCN, lack of psychiatrist at public hospital

Patient-focused barriers to preventive screening, such as Pap testing, and follow-up of abnormal results are similar to other ethnic and cultural minority female populations, including low priority for women's preventive health services; fear of cancer and fatalistic cultural beliefs in less-westernized populations, leading to an understanding of cancer as a death sentence; as well as others such as poverty, transportation issues, childcare issues, and inability to take time away from work to access care. The most important barrier is the one most difficult to eradicate: the lack of understanding that preventive health screenings and early detection can and does save lives.

It is important to understand that the CNMI has some defining characteristics which are essential to comprehending the emerging issues affecting the MCH population. Some of these characteristics demonstrate the uniqueness of the CNMI, as a U.S. Territory, and the program's approach to meeting the needs of families served, and include the following recent summary of an environment scan conducted by the University of Hawaii:

- CNMI, in November 2011, initiated the establishment of the Commonwealth Healthcare Corporation (CHCC), a public corporation. 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 Kagman Section 330 Community Health Center through a co-applicant agreement; the Rota and Tinian Health Centers; and Public Health function and programs.
- The CHCC, since its inception, has struggled with the transition from a government agency to a public corporation. The financial challenges of both the CNMI and CHCC have been severe, and responding to CMS Conditions of Participation has been the most important priority for the CHCC. As a result, the CHCC has not been able to engage in a healthcare transformation planning process.
- CNMI is 4,000 flight miles from Hawaii, the closest state. Travel costs to and from the CNMI are costly since there is only one U.S. carrier that provides direct flights from CNMI to Guam to Honolulu.
- CNMI has a large percentage of the population that are uninsured. The 2010 Census reports the CNMI uninsured population at 34%, more than double the 15% of uninsured in the United States.
- In the CNMI, the Medicaid population is 32%, double the U.S. Medicaid population of 16%.
- CNMI has four private medical healthcare providers and three private insurers.
- CNMI, as well as other U.S. Territories, are capped by legislation on the percentage of Federal Medical Assistance Program (FMAP) funding for the Medicaid program at 55%. In contrast, some states receive over 80%.

Furthermore, 2014 survey results conducted by the Kagman Community Health Center in Saipan shows:

- Chronic disease has a high prevalence, especially the "metabolic syndrome" including obesity, diabetes, hypertension, and hyperlipidemia.
- Health behaviors tend to be poor, with an unhealthy diet and little exercise

- Recommended screening is very low
- Despite this, respondents rate their own health as very good

The implications derived from these reports indicate that the MCHB will continue to provide a collaborative approach to meet some of the issues that hinder the health progression of the targeted domains.

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### **Challenges for Title V Services in CNMI**

The CNMI is a Health Professional Shortage Area with a medically underserved area designation. The isolation and disparities apparent in the CNMI create unique and challenging barriers to a struggling health care system. System barriers include a fragmented and fractured health care delivery system in which prevention and a holistic gender-focused framework play little to no role. While CHCC has increased its ability to provide capacity for preventive screening through recruitment of midlevel providers, it is always a challenge to retain physicians, provide case management and care coordination and health promotion. Due to its geographic location, and being far from tertiary care centers, access to appropriate gynecological services, and specialized services remain a constant concern. Although the capacity of the Division of Public Health Services is limited, MCH continue to seek other ways to assure availability and accessibility of direct health care services for the MCH population groups.

The ability to access affordable and culturally appropriate health care amongst the CNMI's residents serves as a critical challenge even while its population is relatively small in comparison to other jurisdictions receiving U.S. federal funds. While the CNMI is a U.S. Territory and many of its island residents are U.S. citizens, a large portion of its residents remain to be migrants from the islands that entered into a Compact of Free Association (COFA) and foreign nationals, including that of other Pacific Islanders who are migrants from island countries with no U.S. association. Moreover, the Filipino women make up the largest portion of the CNMI's female population. Majority of these women are contract workers, not eligible for Medicaid and with the increase in the minimum wage leading to job loss, many are left unemployed. The unique distinctions amongst the jurisdictions' residents, including the overlapping and deviating cultural needs, such as with being uninsured and the pathway to citizenship, hosts many compounding challenges to accessing critical services, particularly with the maternal and child health population.

There are many laws and regulations which impact the operation of the Title V program in the CNMI. The CNMI State Medicaid Plan and Immunization Law impacts coverage and access to health services for the MCH population. The Family Planning Program also regulates the age consent for teenagers to receive counseling and contraception without the approval of the parents/primary caregiver.

However, the main state regulation which has significantly affected public health services is Public Law 16-51 which established a public corporation to better manage the operations of health care services in 2012. Such was the intent of the legislation when it created the Commonwealth Healthcare Corporation. The law provided the CHCC more flexibility to manage the delivery of healthcare services. Unfortunately, due to lack of planning and transition to the Healthcare Corporation, the Hospital during the first year, was eminently at the edge of losing certification by CMS due to its long history of non-compliance with Medicare Conditions of Participation. Many critical services were suspended including the closure of the only public dental clinic and outlying health centers. The school-based Adolescent Health Clinic was also closed. In addition, critical services such as the Newborn Screening were suspended due to non-payment. Core functions of CHCC

continue to be a major barrier in achieving compliance with federal grants. For instance, the delay in the recruitment of a qualified Chief Financial Officer has left the CHCC struggling to manage the corporation's fiscal matters. However, with the leadership of the Chief Executive Officer, CHCC is working diligently to address these challenges.

## **II.B. Five Year Needs Assessment Summary**

### **II.B.1. Process**

#### **Goals and Vision:**

The CNMI Maternal and Child Health (MCH) Program adopted the following Vision and Mission statements in 2013. CNMI's Vision focuses on healthy mothers, children, and families for a healthier CNMI. The Mission 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.

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 across the life course, 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 Board.

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. 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/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.

#### **Leadership and Stakeholders:**

CNMI's needs assessment process was guided by the MCH Needs Assessment Steering Committee which included the following staff members:

- TaAnn Kabua, Administrator of Maternal Child Health Bureau;
- Shawnalei Ogomoro, SSDI Project Coordinator;
- Allan Dela Cruz, MCH Data Analyst;
- Jose Santos, Systems Administrator;
- Maxine Pangelinian, Fiscal Specialist;
- Ann Marie Satur, Early Intervention Program Service Coordinator, Children with Special Healthcare Needs Coordinator;
- Tony Yarobwemal, MCH Services Coordinator;
- Heather Santos, HOME Visiting Data Specialist;
- Shiella Perez, Newborn Screener and Family Support Coordinator;
- Agnes Ripple, Oral Health Project Coordinator and Dental Hygienist; and

- Yuline Fitial, HOME Visiting Coordinator.
- The group was assisted by Arielle Buyum, who served as facilitator and process consultant.

With leadership from the Maternal Child Health Bureau Administrator, who is 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.

The Steering Committee received support and counsel from the MCH Advisory Board, a group of external and internal stakeholders who serve as advisors to the Bureau. The MCH Advisory Board initially provided critical feedback regarding the overall process methodology and later participated in focus groups and/or completed the priority health issues survey. The Advisory Board reviewed CNMI's new MCH priorities prior to submission and will be reconvened after grant funding in order to identify future collaborative opportunities.

Stakeholders included representation from state MCH programs (including MCH Needs Assessment Steering Committee members), family/youth serving agencies, faith-based agencies, and other key MCH community partners such as health care providers and community-based agency staff, along with representatives from other state agencies and academic institutions. Stakeholders included representatives from public health and other governmental agencies (e.g., the CNMI Public School System and Medicaid Program), staff from community-based organizations and advocacy/interest groups (e.g., The Ayuda Network, Karidat, etc.) along with health care providers/organizations (e.g., The Kagman Community Health Center and FHP Clinic, etc.) and academic partners (Northern Marianas College).

Criteria used for selecting stakeholders included their area of expertise and workplace setting, 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.

#### Methodology:

CNMI assessed the needs of the MCH population using Title V indicators, performance measures and other quantitative and qualitative data. The Steering Committee 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 cross-cutting needs were also examined. The Steering Committee spent several sessions determining data needs and gaps, and reviewing data findings.

Specifically, the Steering Committee:

- Reviewed the 2010 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, US 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. The Steering Committee developed a set of MCH indicators to guide this phase of the work. Findings were also used to populate the MCH Priority Health Issues Survey.

Qualitative methods included the use of the aforementioned survey to MCH clients, stakeholders, parents and community members. MCH received 179 completed surveys covering the six domains. Survey participants chose their top ten issues for each domain, while also identifying any important issues not reflected in the original list. Of the new issues identified, most had been considered by the Steering Committee in earlier phases of the needs assessment process. In addition, qualitative data was received from special population focus groups, such as Department of Corrections inmates, HOME Visiting families, and High School students, and a review of state plans and reports prepared since the last needs assessment. Two special briefing reports were utilized- one the 2014 Kagman Community Health Center Needs Assessment Survey and the other on prenatal care in CNMI.

At the end of the above process, results were summarized from all activities and presented to the Steering Committee. As expected, the focus areas identified across approaches overlapped due to the impact that many of the issues exert throughout the life course. This phase concluded with the identification of 26 potential MCH priorities spanning the six domains. The Steering Committee met concerning the potential priorities identified with the goal of further refining and prioritizing the issues.

Prioritization criteria included considering potential issues in terms of the MCH role, the existence of strategies for intervention, and the ability to demonstrate outcomes/results within five years using specific indicators to measure progress. A Strengths, Weaknesses, Opportunities and Threats analysis was conducted on each identified priority. To gauge capacity, public health management and staff 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.

This phase concluded with the reduction to 13 potential MCH priorities spanning the six domains.

Next was the final prioritization process and state capacity assessment to determine the MCH priorities for FY2016-2020 and in keeping with the guiding principles of the process, the Steering Committee 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. 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: 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. 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.

Realizing the dynamic nature of MCH as well as the depth and breadth of issues specific to these populations,

CNMI will continue to systematically assess needs during the upcoming five-year time frame. Specific work plans will be developed for each priority with goals, objectives, activities and evaluation measures that will drive state MCH activities from FY 2016-2020. As noted above, MCH resources will be allocated and/or shifted to implement the new priorities which will include ongoing evaluation.

## II.B.2. Findings

### II.B.2.a. MCH Population Needs

The MCH population has oscillated dramatically in the past 20 years, see Table 1 below. What looked like a sharp rise in population in 2000, especially amongst the adult women population, was a reflection of the influx of Chinese female factory workers, represented in Table 2 below, in the once booming garment industry in the CNMI. The recent 2010 Census numbers are a more accurate depiction of the current population, reflecting the close of the garment industry as well as federalization of immigration thus limiting in-migration. Table 2 also shows the reduction of the indigenous population, Chamorro and Carolinian, as a result of the recent out-migration of workers due to a worsening economy.

**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

#### Women/Maternal Health:

All public health clinical sites within the CNMI perform women's preventive health exams. However, the most recent

CDC Behavioral Risk Factor Surveillance System (BRFSS) Survey conducted in 2009 found that the community's women were not accessing preventive care. According to the BRFSS Survey, 26.6% of adult females never had a pap test and of the 73.4% that did, 17.4% haven't had a pap test in three or more years which is greater than the US recommended standard. That trend of not accessing preventive care continues today. Last year in 2014 only 1,534 women had non-prenatal outpatient visits at the hospital.

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
- Childcare issues

The CNMI maternal health clinics serve as many women's first entry into medical care or their medical home. As such, the clinics recommend and provide preventive health services in accordance with nationally recognized standards of care. The MCH Program aims to improve the number of clients that follow the recommended standard of care in preventive health services through increased education and outreach efforts and collaboration with community-based programs.

Because the preventive health clinics of the CNMI all exist within the CHCC facilities, clients can avail themselves of multiple public health screening and preventive services in one visit. In this way, the program serve as the gateway to care through partnerships with other public health programs. The MCH Program works closely with the Breast and Cervical Screening Program, Family Planning Program, Smoking Cessation Program, STD/HIV Prevention Program, and other health and social programs. Once again, clients need not make multiple appointments or visit multiple clinics to participate in these program services, thereby allowing for comprehensive and cohesive preventive health care.

An assessment of prenatal care conducted at the only hospital in the CNMI showed that almost 70% of deliveries receive inadequate prenatal care, see Table 3 below. Use of the Kotelchuck data results in a large percentage of prenatal care being labeled inadequate, solely because it starts after the fourth month. However, analysis of data using trimester prenatal care began or using percentage of expected visits attended, confirms the Kotelchuck findings. In addition, 6% of deliveries received no prenatal care at all.

**Table 3** Percent of women (15- 44) with a live birth whose observed to expected prenatal visits are at least 80% on the Kotelchuck Index

	2010	2011	2012	2013
Percent:	22.5	21.1	18.3	33.0
Numerator:	241	218	207	348
Denominator:	1,072	1,033	1,129	1,055

Source: Health and Vital Records Office

MCH Program continues to strive to improve prenatal care adequacy. As part of 2015 Women's Health Month, a new initiative was started in partnership with the Women, Infant and Children (WIC) Program. The first ever Group

Prenatal Care class in the CNMI was launched to allow pregnant mothers to receive their basic prenatal assessments, share informally with other women, and discuss together pregnancy and parenting. This initiative will be continued and evaluated for effectiveness in increasing prenatal care adequacy. In addition, the obstetrician member of the MCH Advisory Board has reported increased anemia among the pregnant population. As such, MCH Program plans to institute mandatory anemia screening of pregnant women.

**Perinatal/Infant Health:**

The perinatal mortality rate in the CNMI in 2014 was 14 per 1,000 live births, see Table 4 below. According to the National Vital Statistics Reports, the most recent national perinatal mortality rate available was 6.26 per 1,000 live births in 2011. When this data is coupled with the 2013 low birth weight percentage of 7% of live births a scenario begins to form in which unplanned pregnancy, late access and inadequate prenatal care, and poverty play a significant role in poor birth outcomes, causing additional stressors on the family, community, the health care system and the government. The MCH Program is committed to improving prenatal care access and adequacy as stated above. Besides the Group Prenatal Care class, MCH has begun the process to open a women and children's health care center on the southern end of the island of Saipan, an area which is currently underserved by both public and private clinics. In addition, there are plans to provide services to remote villages via the mobile health van.

**Table 4** Perinatal mortality rate per 1,000 live births plus fetal deaths

	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Rate:	9.3	8.6	10.7	12.1	14.0
Numerator:	10	9	12	13	15
Denominator:	1,080	1,043	1,122	1,074	1,075

Source: Health and Vital Records Office

The MCH Program has partnered with WIC to improve breastfeeding rates in the CNMI. Unfortunately WIC's involvement is a double edged sword; although breastfeeding support services are available through WIC so is free formula. MCH intends to initiate stronger breastfeeding support to improve the fluctuating breastfeeding utilization, see Table 5 below.

**Table 5** Percent of mothers who breastfeed their infants at 6 months of age

	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Percent:	25.1	51.6	26.0	30.1	47.2
Numerator:	252	464	169	155	377
Denominator:	1,003	899	649	515	798

Source: WIC Program

The pediatrician member of the MCH Advisory Board has reported safe infant sleep issues in that not only are infants not placed on their back to sleep, but do not have a designated solo sleeping area. Co-sleeping is very common among the population. In assessment of the 59 HOME Visiting families, only 23.4% report that they have a designated safe sleeping area for their infant. The MCH Program intends to promote safe sleep over the next project period.

**Child Health:**

Immunizations are a pillar of child health care. However, the overall coverage rates of immunization in CNMI is low at 73.5% in 2014, see Table 6 below. The Immunization Program provides good coverage on vaccinations during vaccine campaigns such as the yearly flu vaccine or the HPV vaccine, but is not adequately covering the child

population. CNMI MCH Program plans to improve immunizations through education and outreach and promotion of vaccinations during well baby clinic visits. Immunizations are currently available at all private clinics on island as well as at the CHCC Children’s Clinic and the Immunization Program Public Health Clinic. The Public Health Clinic is open for walk-ins, thereby increasing accessibility. The recent implementation and strengthening of the Web IZ immunization surveillance system, will help improve tracking and case management of children in need of immunizations.

**Table 6** Percent of children age 19 to 35 months who have received the recommended vaccinations

	2010	2011	2012	2013	2014
Percent	77.0	87.2	49.6	55.3	73.5

Source: CNMI Immunization Program

Until recently, developmental screenings had been provider dependent and no standardized tool was utilized. However, the MCH Program, through the Early Childhood Comprehensive Systems Project, has made great strides in improving developmental screening and referrals as needed. In the past two years, the percent of children screened for school readiness and achievement has increase 23%. This increase is directly related to the implementation of the Ages and Stages Questionnaire 3 (ASQ-3) developmental screening tools at Child Care and Development Fund approved daycare centers. Currently 81% of these daycare centers use the tools. In addition, this year the ASQ-3 Developmental Screening Operating Policy formalizing standardized developmental screening tool at the CHCC’s Children’s Clinic was signed and adopted. Children are screened during the 12-, 18-, 24-, and 36-month well-child visits and can also be administered at the parent’s or provider’s discretion outside of the scheduled screening times.

**Adolescent Health:**

The CNMI teen birth rate for 2014 was 24.1 births per 1,000 females, which is greater the national average of 14.1 in 2012<sup>[ii]</sup>, see Table 7 below.

**Table 7** Rate of birth (per 1,000) for teenagers aged 15-17 years

	2010	2011	2012	2013	2014
Rate:	37.5	27.1	16.3	27.7	24.1
Numerator:	45	29	23	26	22
Denominator:	1,200	1,069	1,413	939	913

Source: Health and Vital Records Office

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. For these reason the MCH Program works closely with the CNMI Public School System (PSS) to prevent teen pregnancy. Unfortunately, in 2012 the High School-based Adolescent Clinic was closed for budget reasons as well as in 2014, the Title X Family Planning federal funding ended. MCH Bureau has continued family planning services and applied and is awaiting notification of award for funding. In addition, in 2014 discussions began with PSS to resume health services at the high schools. These discussions will continue as MCH is committed to adolescent health.

“High-risk sexual behaviors among adolescents are a significant public health concern in the United States. These behaviors account for increasing rates of premature morbidity and mortality by contributing to risk of unintended teen pregnancy, HIV/AIDS, and other sexually transmitted diseases. Complications associated with adolescents’ sexual

risk behaviors may take years to manifest and may seriously compromise adolescents' health and quality of life in adulthood. [...] Ethnically specific cultural and socioeconomic factors may influence high-risk sexual behaviors, which may, in turn, differentially increase risk for HIV/AIDS, other STDs, and unintended pregnancy among Asian and Pacific Islander adolescents.”

The rate of sexually transmitted diseases in the CNMI is soaring. Even with limited testing due to financial and laboratory constraints, the rates of Chlamydia has steadily increased over the past years with a dramatic increase in 2012 and 2013, see Table 8 below.

**Table 8** Rate per 1,000 women aged 15 to 19 years with a reported case of chlamydia

	2009	2010	2011	2012	2013
Rate:	15.1	13.9	5.3	20.7	22.4
Numerator:	39	64	23	36	36
Denominator:	2,582	4,608	4,308	1,741	1,604

Source: HIV/STD Resource & Treatment Center

Reported high risk health behaviors are high among CNMI adolescents, see Table 9 below.

**Table 9** Selected Results from CNMI High School Youth Risk Behavior Surveillance System

	2007	2009	2011	2013
<b>Sexual Behavior</b>	%	%	%	%
Ever had sexual intercourse	49.7	49.5	50.8	46.0
Had first sexual intercourse before age 13	9.8	9.5	8.6	6.9
Had four or more sexual partners in lifetime	14.7	12.1	14.5	11.9
Had sexual intercourse with one or more people during the past 3 months	34.2	33.4	34.4	29.7
Of those who have had sexual intercourse, did not use condom during last sexual intercourse	59.9	57.2	57.6	55.0
<b>Alcohol &amp; Other drugs</b>				
Had at least one drink of alcohol on 1 or more of the past 30 days	41.1	38.8	41.4	33.6
Offered, sold, or given an illegal drug by someone on school property during the past 12 months	36.3	35.9	36.7	36.3

Source: Youth Behavior Risk

Survey

The MCH goal is to encourage positive health behavior activity in adolescents, through comprehensive interventions at age-appropriate levels in a culturally-sensitive manner that will impact the frightening possibilities of adolescent risk behavior activity, including, but not limited to:

- unplanned pregnancy and teen birth

- sexually transmitted diseases in the adolescent and young adult population
- alcohol use, and
- drug use.

Based on the data, the need for educational and clinical services is apparent at all high schools. On-site educational and clinical services in the high school setting allow ease of access, confidentiality, and personal counseling within an environment that is neither restrictive nor intimidating. In addition, the program plans to implement a collaborative effort with PSS to introduce a health promotion into the middle schools, including sexuality and violence. Risky health behavior is occurring at a young age in the CNMI, see Table 10 below and the importance of offering education and skills prior to high school is vital to positive outcomes.

**Table 10** Selected Results from CNMI Middle School Youth Risk Behavior Surveillance System

	2007	2009	2011	2013
<b>Sexual Behaviors</b>	%	%	%	%
Have had sexual intercourse	18.4	17.8	17.6	17.0
Have had 4 or more sexual partners	5.8	6.1	5.6	5.3
Have had sex before age 11	5.2	6.1	5.5	4.4
Of those who have had sexual intercourse, did not use a condom during the last intercourse	46.3	45.9	51.5	48.5
<b>Alcohol &amp; Other drugs</b>				
Ever having a drink of alcohol	53.0	52.4	54.9	48.5
Ever having used marijuana	31.1	33.3	34.7	31.3
<b>Violence</b>				
Have been bullied on school property in the last year	n/a	48.8	55.5	63.7

Source: Youth Behavior Risk Survey

The selected results of the 2009 CNMI middle school YRBSS survey cited above indicate a real and immediate need to provide outreach and public health intervention services to young adolescents in the middle school setting. MCH Program energies are needed to collaborate with PSS in designing a comprehensive program to deter emotional and physical violence and bullying; abstinence and safe sexual practices promotion; addressing social pressures that influence behavior; and culturally-sensitive skills-building in communication, negotiation, and conflict-resolution techniques to the middle school student population.

**Children with Special Health Care Needs:**

Currently the CNMI does not have a database system to report, track or register a child as one with special health care needs. Therefore, the program does not have an accurate count to determine how many CSHCN are being seen and/or receive appropriate and timely health care case management services. As a stand in, the program tracks the percent of Supplemental Security Income beneficiaries that receive services, see Table 11 below.

**Table 11** Percent of State Supplemental Security Income beneficiaries less than 16 years old receiving rehabilitative

services from the CSHCN Program.

	2009	2010	2011	2012	2013
Percent:	94.9	72	50	50	70.1
Numerator:	282	203	141	141	232
Denominator:	297	282	282	282	331

Source: CSHCN Survey

The lack of a tracking system is a major shortcoming of the program. Without such a system it is difficult to measure or quantify most aspects of the reach and success of the program. Most children in the program are identified by their enrollment in PSS Early Intervention Services, when diagnosed as deaf or hard of hearing, or seen and referred by Shriners during Shriners annual visit. Currently there is no data sharing agreement with PSS Special Education, therefore the program is unaware how many children have an Individual Education Plan.

To begin tracking CSHCN, the program is creating a registration form to be filled out by the provider who recognizes a child with a special health care need. This form will include demographics and the child's condition. Therefore besides beginning a basic count of children, this form can help the program identify where and what by type of provider CSHCN are being seen. In addition, the Program developed and implemented an Access database for CSHCN. However, there are some components that need improvement for better data collection and queries. Training on how to use the database will be needed as well.

Cross-cutting:

The Public Health Dental Clinic, under the CHCC's Division of Public Health Services, on the island of Saipan, serves the entire CNMI community of Saipan, Tinian, and Rota. It is the only public dental clinic. There are peripheral Public Health Dental Clinics on the islands of Rota and Tinian that provide limited services. Thus, the Dental Clinic on Saipan is the referral clinic for the two islands especially for the Medicaid and uninsured population. Furthermore, it is also the referral clinic for the Kagman Community Health Center which caters to vulnerable and underserved population.

The Dental Clinic, through a Memorandum of Agreement with the Head Start Program and PSS, has the only established school prevention programs in the CNMI. Although the purpose of the Fluoride Varnish and Sealant programs is to prevent dental caries among children in the CNMI, data shows that there is already a high incidence of dental caries among participating students even before entering the program, see Table 12 below. Along with the supporting data, both medical and dental care providers have noted tremendous deficiencies in the oral health status of children in the CNMI.

**Table 12** Head Start Fluoride Varnish Prevention Program (1st Visit) – School Year 2014-2015

	Students Assessed	Students w/Caries	% w/Caries	Students w/ Application
Total:	377	247	66%	362

Source: Public Health Dental Clinic, Division of Public Health Services, CHCC

The prevalence of dental caries remains one of the most unmet health needs especially among young children in the CNMI. Supported by data in the Table above, 66% of students examined already have dental caries. For most of the children in Head Start, their first dental visit is through the Fluoride Varnish Program.

Impeding priorities in families' life creates challenges and barriers in seeking preventative health screenings including for oral health. Poor oral health literacy contributes to not seeking preventive oral health services as

individuals may not understand the connection of good oral health in relation to their general health. The Dental Clinic has to be in the forefront of providing guidance to redefine the roles of health professionals in the delivery of oral health services.

CNMI experiences heightened oral cancer diagnoses due, in large part, to a high incidence of chewing betel nut. Data from the CNMI Cancer Registry shows that from 2007- 2014, 35 people were diagnosed with oral cancer ranging in age from 35-50 years. Betel (areca) nut chewing is often used in combination with tobacco and slaked lime (predominantly calcium hydroxide). Use of betel nut in adults is very high in the CNMI and starts at a young age. The average age for initiation of chewing betel nut is 12 years. Betel nut is sold in gas stations, grocery stores, and roadside stands and can be obtained from homegrown trees. It is easily available throughout the CNMI and there is no minimum age for purchase.<sup>[iv]</sup>

To better understand the unmet health needs of the target population, it is important to understand the effects of the economic downturn in the CNMI on the population as it has greatly affected the population’s ability to seek health care. People are facing the very real truth of choosing to buy food for their families over seeking preventive services or paying for health insurance premiums. Therefore, the community tends to seek health care for acute situations and severe conditions only when they cannot avoid it – a process that most often leads to poor outcomes and expensive specialty care. 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 insured are ever higher than the overall population of 34%, see Table 13 below.

**Table 13** Insurance status of children age 1-9 years

Year	Percent without health insurance	Percent with Medicaid
2011	68.4	27.7
2012	60.6	28.5
2013	56.9	38.1
2014	50.0	49.4

Source: RPMS, CHCC

As the number of children with Medicaid has increased over the past four years, those without any health insurance coverage has decreased. However, the number uninsured still remains remarkably high at 50% of children. The same improvement in insurance status can be seen in women utilizing the CHCC for medical care, see Table 14 below. However, again the uninsured rate of 25% is well above the national average of 15%.

**Table 14** Insurance status of women at CHCC

Year	Private Insurance	Medicaid	Uninsured
2008	24%	27%	49%
2013	20%	55%	25%

Source: RPMS, CHCC

Medicaid Expansion as part of the Affordable Care Act (ACA) accounts for much of the increase in coverage. However in August 2014, the Department of Health and Human Services determined that the ACA does not apply to the US territories including the CNMI. Therefore, at this time the CNMI does not know if Medicaid will be able to continue expanding services past 2019 when the first round of ACA funding will expire. This uncertainty means the

program must be prepared to return to an uninsured rate of almost 70% of children as it had in 2011.

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[i] CNMI Department of Commerce, Division of Central Statistics, BRFSS Report, 2009.

[ii] Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, Vital Signs: Births to Teens Aged 15-17 Years- US, 1991-2012, Vol. 63; 14.

[iii] Sasaki and Kameoka, Ethnic Variations in Prevalence of High-Risk Sexual Behaviors Among Asian and Pacific Islander Adolescents in Hawaii, American Journal of Public Health, October 2009, Vol. 99;10.

[iv] Comprehensive Cancer Control Plan for the CNMI, 2007-2012, page 28. Saipan: 2007.

## **II.B.2.b Title V Program Capacity**

### **II.B.2.b.i. 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 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 CNMI is self-governing with locally elected Governor, Lieutenant Governor, and Legislature.

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 Medical Director also provides oversight to the program. There are three divisions under the corporation: 1) Public Health -- provides preventive and community health programs of which many are federally funded; 2) Community Guidance Center; and 3) Hospital. The following are senior leadership positions: Ms. Esther Muna, Chief Executive Officer; Ms. Margarita Torres-Aldan, Director of Public Health Services; and Dr. Daniel Lamar, Medical Director for Public Health.

The Division of Public Health is responsible for administering the Title V MCH Program. The MCH Program falls under the recently formed 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, Early Childhood Comprehensive Systems, Oral Workforce- Teeth for Health- Project, H.O.M.E. Visiting, and State System Development Initiative. The Administrator of the MCH Bureau 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.

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. Please see the attached Organizational Chart for other programs within the Division of Public Health.

### **II.B.2.b.ii. Agency Capacity**

The MCH Program through its partnership with the Hospital's Women and Children's Clinic and the Community Guidance Center provide primary and preventive health services to the community. Services include medical, dental,

mental health, substance abuse counseling, women's health, nutrition counseling, and family planning. Collaboration with other Public Health programs and community partners makes it possible to bring health services out into the community. This work is supplemented by enabling services including outreach, case management, educational materials, and transportation to MCH target populations. The strategy is to work with the community and empower the community with tools and information to make informed decisions to live healthier lifestyles. The MCH Program has strong collaborative relationships with key physician providers for the MCH populations. Dr. Grant, an Obstetrician/Gynecologist; Dr. Steadman, a Pediatrician; Dr. Rohringer, an Emergency Room Physician; and Dr. Lamar, the Public Health Medical Director, all guide and support the program and serve on the MCH Advisory Council or CNMI Collaborative Improvement and Innovation Network (CollIN) Team. Below is a description of capacity by domain.

### **Women/Maternal Health:**

Prenatal care is provided at the Women's Clinic located at the CHCC, and Rota and Tinian Health Center. The first prenatal visit involves an intake/interview by a nurse, physical exam (Pap test), blood work, counseling, and HIV testing. The revisit exams include monitoring the baby's growth and development, monitoring the mother's health, nutritional counseling and education. There are four OB/GYNs 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.

Postpartum clinic provides assessment of maternal and fetal health after delivery as well as family planning counseling and contraceptives. Mothers are provided with hematocrit screening, blood pressure and weight check, and physical examination. Mothers are counseled on family planning methods and those who decide on using a family planning method are given their choice of contraceptives also at no cost. Family planning services are provided every day for scheduled appointments and walk-ins.

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 to women over 40 years of age at no cost to women that meet the Program's criteria. Eligibility assistance and transportation is provided to clients; transportation includes air fare to clients from Rota and Tinian for mammograms. In addition, the program conducts outreach presentations on early detection and prevention including risk factors. Supplemental activities include expanded outreach activities with partners such as MCH during awareness months.

Comprehensive Women's Health and Gynecological services are provided at the Women's Clinic and Rota and Tinian Health Centers. The referral clinic for complicated cases is the CHCC's Women's Clinic. Health screenings such as blood sugar, blood pressure, weight, etc. is provided daily. This is also conducted during community events.

### **Perinatal/Infant Health and Child Health:**

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

Newborn assessments completed include physical examinations, monitoring of weight gain, and cord care. Breastfeeding is also discussed and education for proper technique or identified issues is completed.

Well Baby/Child exams are provided at the Children's Clinic. Services provided include immunization, health education and counseling including nutrition, injury prevention, safety, assessment and monitoring for growth and development and other underlying health problems, and physical examinations. Referrals 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 Immunization Program ensures availability and accessibility of vaccination services. Immunization is provided at the public health facilities and all five private clinics. The Public Health Clinic is open for walk-ins, improving accessibility. The recent implementation and strengthening of the Web IZ immunization surveillance system, will help improve tracking and case management of children in need of immunizations. The MCH Program works with partners, such as WIC, to provide awareness on the importance of age appropriate immunization.

Newborn Hearing Screening has successfully screened 98% of newborns before hospital discharge. Quality improvement activities are focused on reducing loss to follow-up. The Early Hearing Detection and Intervention surveillance system has improved the identification of infants not screened for hearing loss and those that have not returned for the second hearing test.

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.

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 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 first, fifth, 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. In addition, much work for this population is done in collaboration with the PSS. Mental health and social services are provided through the Community Guidance Center (CGC).

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 described above. In addition they collaborate with the CGC to promote 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.

### **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 Tripler Hospital, and Shriner Children Hospital visit CNMI. 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 MCH works closely with the Medicaid office to promote eligibility and enrollment. MCH has also devoted a staff member to assist clients with enrollment in the CHCC based income-based sliding fee program to provide discounted services to those that qualify.

#### **II.B.2.b.iii. MCH Workforce Development and Capacity**

The MCHB management and team (see MCHB Organization Chart) 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. For example, the ECCS Coordinator, Maxine Pangelinan, serves on the Youth Advisory Council established by the CNMI Criminal Justice and Planning Agency. She also served on the advisory body responsible for the development and approval of the CNMI Early Learning Guidelines for infants and toddlers. The recruitment of a MCH Services and CSHCN Coordinator has tremendously improved the service linkages for families, including children with special health care needs, in the CNMI. Dr. Jeanolivia Grant not only provides input and guidance for the program, but recently took on the role as the CNMI Title V Epidemiologist working alongside the SSDI Project Coordinator, Shawnalei Ogumoro, to inform decision making through the use of quantitative and qualitative data and evaluation of program performance. Additionally, professional development is available and continuous to meet the evolving needs of the population. Working closely with all MCH populations and partnering agencies helps to assure that in turn, MCHB promotes and utilizes the best policy and practice appropriate to the CNMI.

MCH Program is administered under the leadership of the Chief Executive Officer, Esther L. Muna, who appoints the Directors of the three Divisions- Public Health Services, Community Guidance Center, and Hospital and Directors of the Tinian, and Rota Health Centers, see attached CHCC Organizational Chart. The Director and Medical Director of DPHS are locally supported FTEs that work directly with the MCH Bureau to provide support and guidance. See attached biographical sketches for senior management personnel. The MCH Program supports the following full/part time positions:

**OB/GYN Physician/MCHB Epidemiologist:** Jeanolivia Grant, MD, graduated from Thomas Jefferson University Medical School and completed her residency at Temple University in Philadelphia. She completed her master's degree in Public Health from the University of North Texas in Epidemiology. She is the Department Chair for the CHCC OB/GYN unit and provides clinical services as well as input and assistance to the preventive programs at the Division of Public Health Services. She maintains a .3 FTE as the MCHB Title V Epidemiologist.

**MCH Program Coordinator/MCH Bureau Administrator:** TaAnn Temeing Kabua recently assumed duties as the MCH Program Coordinator. She holds an AA degree in Liberal Arts from the Leeward Community College in Honolulu HI. She is currently pursuing a BS in Education with a concentration in Rehabilitation and Human Services and is expected to graduate this year. Prior to becoming the MCH Program Coordinator, she managed the overall programmatic activities for the SSDI Grant for over two years. She served in the U.S. Army on active duty as an Automated Logistical Specialist. Ms. Kabua also volunteers in community organizations and serves as a founding member of one of the sports organizations, engaging adolescents in softball tournaments, in the CNMI. She is a member of Marianas Young Professionals, a non-profit organization representing a broad range of professionals across the CNMI.

**SSDI Project Coordinator/MCHB Data Analyst:** Shawnalei Ogumoro graduated from Eastern Oregon University with a BS in Anthropology/Sociology, with emphasis in Anthropology in 2008. Related coursework completed included: culture health and illness, information access, and statistics. Ms. Ogumoro was the former data manager for the MCH H.O.M.E Visiting Project. She currently serves as the SSDI Project Coordinator and Data Analyst.

**MCH Services Coordinator:** Tony Yarobwemal serves as the MCH Service Coordinator and Acting Family Planning Manager. He holds a BS 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. He was also a nursing assistant for eight years at CHCC before moving to PSS. Mr. Yarobwemal volunteer work for faith-based and community organizations such as the teaching at the Confraternity of Christian Doctrine classes has linked many families to the MCH Program. His respectable reputation in the community as well as his knowledge of health programs have been valuable assets for the program.

**Children with Special Health Care Needs Coordinator:** Ann Marie Satur administers all activities for CSHCN. She was born and raised in Saipan, CNMI. She graduated from Northern Marianas College Saipan, MP in 2007 and graduated from Northern Marianas Academy Saipan, MP also in 2007. Ms. Satur attended Old Dominion University Norfolk, VA from 2007-2009. Ms. Satur has been working with CHCC since 2011 as an Early Intervention Services Coordinator. She has taken the role of CSHCN Coordinator to ensure the activities detailed in the new CNMI MCH State Action Plan and priorities for CSHCN are met.

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 live for our MCH population. The programs administered under the CNMI MCH Bureau continue to meet major milestones and objectives. For more information about key MCHB staff see Section F, 2.

### **II.B.2.c. Partnerships, Collaboration, and Coordination**

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) establish a network linkage with other providers to inform them of health news, health alerts, awareness events, training, etc.; and 4) develop partnership with other agencies to ensure continuity of care. The strength of MCH

Program's work is through collaboration with partners.

Much of the island-wide work accomplished by MCH staff is done in collaboration with other state agency staff, particularly those who work within the Division of Public Health, and the Department of Education. MCH personnel work with other state agency staff on a nearly daily basis through coalitions, task forces, advisory groups, committees, and through cooperative agreements.

The CNMI Department of Education, in particular the Early Intervention Service, is an essential partner of the CSHCN Program. Together the agencies offer services for children served by the CSHCN Program. A staff member represents the program and the department on the Interagency Coordinating Council.

The CNMI Department of Education is an essential partner in activities relevant to early childhood state systems building efforts; the coordinated school health model; work with school counselors; and school-based activities. They also work with the CNMI Community Guidance Center, who leads underage drinking prevention efforts. The Community Guidance Center 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 MCH Program works with the HRSA 330e-funded Kagman Community Health Center to improve accessibility and expand primary care services for low-income and vulnerable populations. These efforts include information and data sharing; policy development; and assisting communities with applying for health professional shortage area and medically underserved designations.

The MCH and WIC Programs have worked collaboratively for many years. Current efforts are focused on increasing breastfeeding rates and decreasing childhood overweight and obesity.

Family Planning is housed within the MCH Bureau. Efforts to address unintended pregnancy, preconception health and preventing risky teen sexual behavior are targeted to both family planning and MCH activities. Currently, MCH funds are not used for direct family planning services, but rather to support population-based activities around unintended pregnancy prevention. This unit has strong ties to the programs that work on STD/HIV.

The MCH Program also works with the Immunization Program via interdepartmental activities, such as the H1N1 and HPV School Vaccination Campaigns.

Relationships with the Non-Communicable Disease Bureau are strong and support work between MCH projects and programs such as Diabetes, Cancer, Tobacco Control and other chronic disease prevention and health promotion. For example, the NCD Bureau has long worked with MCH to promote healthy weight among children.

The Health Vital Records Office is an established partner of the MCH Program. This long-term relationship has led to the development of MCH-specific data and resources. The rehiring of a Division Epidemiologist as well as a part time MCH Epidemiologist will further strengthen the MCH Program's ability to gather, interpret and use data at the state and community level.

The MCH Program has an established working partnership with Northern Marianas College (NMC) for training needs of both clinical and programmatic staff, conducting awareness activities in nutrition and physical activity and preventing and controlling non-communicable disease. The NMC School of Nursing and Emmanuel Nursing College provide volunteers during events such as HPV School Campaign and H1N1 and health fairs. All Division programs conduct outreach activities at schools during their health fairs, science fairs, nutrition awareness event, etc.

Each unit manages on-going advisory groups and specific task forces that are made up of public and private partners that share concern and responsibility for addressing the needs of women, children and families. Additionally, staff participates in partnerships led by colleagues within other state, federal and community organizations.

The MCH Title V Program staff work closely with parent support groups, church leaders, women's groups, and community and traditional leaders. However, the current use of the parent/consumer partnership is limited in the

CNMI. Outside the children with special health care needs population, the parent/consumer partnership is non-existent at this time. Within the children with special health care needs population CNMI has an Inter-Agency Coordinating Council (ICC) consisting of representative from Public Health, Special Education, community groups such as churches, NGOs and advocacy bodies, government offices as well as parents and consumers of the CSHCN services. The diversity of the population is represented appropriately. As a group focused on CSHCN, they are educated and aware of CSHCN competencies but not MCH core competencies overall. The ICC meets quarterly and has approximately twenty members, four of which are parents and consumers. This council receives no compensation or monetary incentive for participation. Parents and consumers have and equal say and equal vote to other members in the business of the council. Council business centers around program policies and guidelines, access issues, service delivery, and needs and gaps in services provided. The MCH program intends to expand its parent/consumer partnership in the coming years to improve public input into the entire program and its policies and objectives. In addition to the ICC, annual surveys are conducted to seek family and caregiver's assessment of services and how they are provided. There are three types of surveys depending how long the child has been in the CSHCN Program.

## II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Women's/Maternal Health: Improve Women's Health Through Cervical and Breast Cancer and Anemia Screening.	New	
2	Perinatal/Infant Health: Improve Perinatal/Infant Outcomes Through Early and Adequate Prenatal Care Services and Promoting Breastfeeding and Safe Sleep.	New	
3	Child Health: Improve Child Health Through Providing Vaccinations and Screening for Developmental Delays.	Continued	
4	Adolescent Health: Improve Adolescent Health by Promoting Healthy Adolescent Behaviors & Reducing Risk Behavior (i.e. drug & alcohol use, bullying) & poor outcomes (i.e. teen pregnancy, injury, suicide)	Continued	
5	CSHCN: Provide a Medical Home for Children Identified as CSHCN	New	
6	Cross-cutting: Improve Insurance Status of Children and Pregnant Mothers.	New	
7	Cross-cutting: Improve Oral Health of Children & Pregnant Mothers	New	
8	CSHCN: Improve identification of CSHCN Through Screening for Developmental Delays.	New	

## C. State Selected Priorities

The CNMI selected the final eight priorities based on the needs assessment finding.

Improve women's health through cervical and breast cancer and anemia screening

Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding

and safe sleep

Improve child health through providing vaccinations and screening for developmental delays

Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide)

Provide a medical home for children identified as Children with Special Health Care Needs

Improve identification of CSHCN through screening for developmental delays

Improve oral health of children

Improve insurance status of children and pregnant mothers

The comparison to prior priorities identified in 2010 is slightly different given the new domains presented by HRSA MCHB. Also, CNMI MCH program took a broader view of the priorities to improve overall health through specific actions. The more specific goal based measures (i.e. Increase women reporting exclusive breastfeeding through 6 months) can be seen in the chosen National Performance Measures and State Performance Measures. Below is a table of the old priorities compared to the new with notations of changes.

<b>2010</b>	<b>2015</b>	<b>notes</b>
To increase the percent of mothers who breastfeed their infants at hospital discharge	Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep	Replaced and combined to focus on outcome and include breastfeeding as a factor towards that outcome
To ensure early entrance into prenatal care to enhance pregnancy outcomes for pregnant women enrolled in Medicaid	Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep	Replaced and combined to focus on outcome and include all women not just those enrolled in Medicaid
Improved case management of pregnant women identified as 'high-risk'		Replaced
To increase the proportion of women aged 18 years and older who have ever received a pap smear	Improve women's health through cervical and breast cancer and anemia screening	Continued although combined
To increase the proportion of women aged 40 years and older who have ever received a mammogram	Improve women's health through cervical and breast cancer and anemia screening	Continued although combined

To reduce the proportion of children ages 12 months to 5 years who are at risk of overweight or obese		Replaced
Increase developmental screening for children 0-5 years old	Improve child health through providing vaccinations and screening for developmental delays	Continued although combined
To lower the birth rate among Chamorro teenagers aged 15-18	Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide)	Continued although combined
Reduce adolescent risk behaviors relating to alcohol and other drug use	Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide)	Continued although combined
Input information on infants with a diagnosis at birth into the Birth Defects Registry within 6 months		Replaced
	Provide a medical home for children identified as Children with Special Health Care Needs	New
	Improve identification of CSHCN through screening for developmental delays	New
	Improve oral health of children	New
	Improve insurance status of children and pregnant mothers	New

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.

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/partners to enhance collaboration, while looking for opportunities to coordinate and integrate MCH efforts externally and internally across the MCH continuum.

CNMI assessed the needs of the MCH population using Title V indicators, performance measures and other quantitative and qualitative data. The Steering Committee 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 cross-cutting needs were also examined.

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. The Steering Committee developed a set of MCH indicators to guide this phase of the work. Findings were also used to populate the MCH Priority Health Issues Survey.

Qualitative methods included the use of the aforementioned survey to MCH clients, stakeholders, parents and community members. MCH received 197 completed surveys covering the six domains. Survey participants chose their top ten issues for each domain, while also identifying any important issues not reflected in the original list. Of the new issues identified, most had been considered by the Steering Committee in earlier phases of the needs assessment process. In addition, qualitative data was received from special population focus groups, such as Department of Corrections inmates, H.O.M.E. Visiting families, and High School students, and a review of state plans and reports prepared since the last needs assessment. Two special briefing reports were utilized- one the 2014 Kagman Community Health Center Needs Assessment Survey and the other on prenatal care in CNMI.

At the end of the above process, results were summarized from all activities and presented to the Steering Committee. As expected, the focus areas identified across approaches overlapped due to the impact that many of the issues exert throughout the life course. This phase concluded with the identification of 26 potential MCH priorities spanning the six domains. The Steering Committee met concerning the potential priorities identified with the goal of further refining and prioritizing the issues.

Prioritization criteria included considering potential issues in terms of the MCH/public health role, the existence of strategies for intervention, and the ability to demonstrate outcomes/results within five years using specific indicators to measure progress. A Strengths, Weaknesses, opportunities and Threats (S.W.O.T.) analysis was conducted on each identified priority. To gauge capacity, public health management and staff 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.

This phase concluded with the reduction to 13 potential MCH priorities spanning the six domains.

Next the final prioritization process and state capacity assessment to determine the MCH priorities for FY2016-2020 and in keeping with the guiding principles of the process, the Steering Committee 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. 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 performance or 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. 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.

One example of a priority that was discussed but not included in the final list are decreasing the number of low-risk cesarean deliveries. Although this was discussed as a possible issue it was found that most of these types of deliveries occurred amongst our transient delivery population, often called tourist births, and by the one private physician who services this specific population. The CNMI is accessible to Asian countries via direct flights in under five (5) hours. Because of US Citizenship Laws, babies born on US soil are considered US citizens. Therefore the CNMI receives many foreigners who come here specifically to deliver their child. Because the physician is a private physician and does not work for the CHCC Hospital and because the infants are taken back to their parents' home country it would be difficult to influence the reduction and track the outcomes.

Transition to adult life for children with special health care needs is another priority that was discussed but not chosen. Although this is important and worthwhile, at this time it is unrealistic to pursue. As discussed in the needs assessment the CSHCN Program currently lack the capacity to identify their population. It also lacks an information sharing agreement with the Public School System. As such, the Steering Committee felt it was a greater priority to build the foundation of identifying and tracking the CSHCN population before instituting a change to their transitional services which are currently an unknown.

## II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

### NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	19.0	20.0	21.0	22.0	23.0

### NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	48.0	51.0	54.0	57.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	43.0	45.0	47.0	50.0

### NPM 5-Percent of infants placed to sleep on their backs

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	50.0	55.0	60.0	65.0

### NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	60.0	64.0	68.0	72.0	76.0

**NPM 9-Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75.0	70.0	65.0	60.0	55.0

**NPM 11-Percent of children with and without special health care needs having a medical home**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	50.0	55.0	60.0	65.0

**NPM-13 A) Percent of women who had a dental visit during pregnancy**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	5.0	10.0	15.0	20.0	25.0

**NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.0	12.0	14.0	16.0	18.0

**NPM 15-Percent of children ages 0 through 17 who are adequately insured**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	55.0	60.0	65.0	70.0

#### **D. Link State Selected Priorities with National Performance Measures**

The CNMI selected the following eight (8) National Performance Measures in relation to the identified priority areas.

<b>National Performance Measure by Domain</b>	<b>Selected Priority</b>
<b>Women's/Maternal Health</b>	
#1. Increase women receiving a well woman visit including Pap and mammogram	Improve women's health through cervical and breast cancer and anemia screening
<b>Infant/Perinatal Health</b>	
#4. Increase women reporting exclusive breastfeeding through 6 months	Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep
#5. Increase mothers reporting they most often place the baby on its back to sleep in a separate sleep area	
<b>Children's Health</b>	
#6. Increase children receiving developmental screening	Improve child health through providing vaccinations and screening for developmental delays
<b>Adolescent Health</b>	
#9. Decrease adolescents bullying	Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide)
<b>Children with Special Health Care Needs</b>	
#11. Increase CSHCN with a medical home	Provide a medical home for children identified as Children with Special Health Care Needs
To be accomplished through NPM #6	Improve identification of CSHCN through screening for developmental delays
<b>Cross-Cutting</b>	
#13. Increase children receiving a preventative dental visit	Improve oral health of children
#15. Increase children who are adequately insured	Improve insurance status of children and pregnant mothers

As apparent from the above table some of the component of the selected priority areas will be covered through the State Performance Measures (please see Section E below).

The National Outcome Measures associated with each identified priority area is described in the table below.

<b>National Outcome Measure by Domain</b>
<b>Women’s/Maternal Health</b>
Low birth weight rate (%)
Preterm birth rate (%)
<b>Infant/Perinatal Health</b>
Infant mortality rate per 1,000 live births
Postneonatal mortality rate per 1,000 live births
Sleep-related SUID per 100,000 live births
<b>Children’s Health</b>
Percent of children meeting the criteria developed for school readiness
<b>Adolescent Health</b>
Adolescent mortality ages 10 through 19 per 100,000
Adolescent suicide ages 15 through 19 per 100,000
<b>Children with Special Health Care Needs</b>
Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations
<b>Cross-Cutting</b>
Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months
Percent of children without health insurance

The above measures were selected because of their relationship and propinquity to the priorities that were identified as part of the needs assessment.

**D. Link State Selected Priorities with State Performance Measures**

The CNMI selected the following five (5) State Performance Measures in relation to the identified priority areas.

<b>State Performance Measure by Domain</b>	<b>Selected Priority</b>
<b>Women's/Maternal Health</b>	
Increase pregnant women screened for anemia	Improve women's health through cervical and breast cancer and anemia screening
<b>Infant/Perinatal Health</b>	
Increase early and adequate prenatal care-women receiving prenatal care beginning in first trimester stratified by insurance	Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep
<b>Children's Health</b>	
Increase children receiving routine vaccines	Improve child health through providing vaccinations and screening for developmental delays
<b>Adolescent Health</b>	
Decrease adolescent suicide	Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide)
Decrease teen pregnancy rates among 13-14 and 15-17 year olds	
<b>Cross-Cutting</b>	
Increase early and adequate prenatal care-women receiving prenatal care beginning in first trimester stratified by insurance (Same SPM as Infant/Perinatal Health)	Improve insurance status of children and pregnant mothers

## **II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures**

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

## **II.F. Five Year State Action Plan**

### **II.F.1 State Action Plan and Strategies by MCH Population Domain**

In accordance with the legislative mandates of Title V and MCHB transformation, the CNMI has guided its program and policies at all levels and activities. These program activities are described and categorized by the four levels of the MCH pyramid. Please note that the program activities or the role that MCH Program plays in the implementation of activities for each performance measure varies. The program activities are expected to positively impact the national performance and outcome measures and state performance and outcome measures for the MCH program. The transition to a Corporation has proven challenging (and still is) as the focus was on the Hospital side especially as the CMS corrective action plan continues. The CNMI formed a Bureau consisting of MCH programs with a family-centered approach and life course perspective, taking into consideration the social and economic challenges of families in this remote territory. Family partnership is even more critical and considered in the delivery of healthcare services, especially since the CHCC became a semi-autonomous agency responsible for the primary and preventative health services for the community, especially the indigent. To align resources and improve effectiveness in all areas and programs serving the unique needs of the MCH population, priorities identified from the 2010 needs assessment guided MCH Program the CNMI in 2014.

Please refer to the next page to view the State Action Plan Table in a landscape page orientation.

## State Action Plan Table

### State: Northern Mariana Islands

#### CNMI MCH Program Five-Year State Action Plan

#### Women's/Maternal Health:

The needs assessment process for the CNMI's 2016-2020 MCH Block grant identified areas of improvement for women's health and related programs. Approximately 70-80% of pregnant women do not receive adequate prenatal care (further discussed below in Perinatal/Infant Health), primarily due to lack of insurance/funding for care; the concept of pre-conceptual care is unfamiliar while reproductive planning is nonexistent; only 17% of women receive the appropriate screening for both breast and cervical cancer; routine sexually transmitted infection screening is limited; and behavioral health issues are routinely not addressed. Many of the women do not have private insurance and are not eligible for Medicaid. Evidence-based strategies are needed in order to provide women, and through them, their families, optimum, quality care. The CNMI will include a variety of strategies including 1) promotion of preconception care and preventive screenings; 2) advocating for improved coverage for women's health; and 3) developing care coordination to address women's health services.

With the priority to improve women's health through cervical and breast cancer and anemia screening, the Maternal and Child Health Bureau (MCHB) anticipates planning and implementing, by reporting year 2017, culturally appropriate evidence-based activities aimed at increasing the percentage of women in the CNMI who improve their overall health by seeking medical care and preventive services. Meanwhile, MCHB has started key activities in line with such priority. Activities include updating the Memorandum of Understanding (MOU) between the State Medicaid Office and the Division of Public Health Services (DPHS) – MCHB to include amongst other data sharing services, the allowance of MCHB to receive, review, and submit MCH client's Medicaid application for processing, and furthermore, to expedite the processing of MCH such applications. Other activities include local TV commercials, local magazine/newspaper/radio advertisements, poster distributions, and social media posts (MCHB Facebook and Twitter accounts).

To ensure that such measure is collected and tracked, MCHB through collaboration with the State Systems Development Initiative (SSDI) Program, will incorporate the data field for this measure into its Title V Data Repository System. Additionally, MCHB anticipates working closely with the Commonwealth Healthcare Corporation's (CHCC) Medical Laboratory regarding data on anemia screenings, specifically for all women of child bearing age, as well as working with the Breast and Cervical Screening Program (BCSP) under the Non-Communicable Disease Bureau. Collaboration between all departments will not only include data sharing but also on strategic planning and activities designed to achieve improving such measure.

Impact made in the priority area identified in this domain will rely heavily on the overall success of the key activities outlined below. As a mechanism to evaluating such measure's success/deficiency, in regards to proposed activities, MCHB will work with CHCC Medical Laboratory, BCSP and other key partners to monitor data and use a PDSA to implement quality improvement projects in order to meet the set objectives. Involvement of key partners identified within the plan for the implementation and evaluation of key activities will be vital in determining successes or deficiencies.

**DOMAIN: Women/Maternal Health****PRIORITY:** Improve women’s health through cervical and breast cancer and anemia screening.**NOM:** Low birth weight rate (%)

Pre-term birth rate (%)

**NPM #1: Increase women receiving a well woman visit including Pap and mammogram.**

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase number of women who received a Pap and mammogram screenings by 10%.	Reduce barriers to Pap and mammogram screenings by improving access to services.	<ul style="list-style-type: none"> <li>-Offer Pap screenings in mobile clinic, community health centers, and other non-traditional sites (i.e. NAP, WIC, and Village Centers).</li> <li>-Advocate for Medicaid and Private Insurance coverage for patients not eligible for BCSP Pap and mammogram screenings.</li> <li>-Enhance administrative services such as improving scheduling and care coordination.</li> <li>-Maintain partnership with the CNMI BCSP, with a focus on improving follow-ups for women of childbearing age with positive screening tests.</li> <li>-Maintain partnership with CHCC Women’s Clinic to review existing screening policies and procedures and amend if necessary.</li> <li>-Maintain partnership with all public and private clinics to include as a part of the well woman visit, risk assessments and education and health promotion counseling for Pap and mammograms</li> </ul>	<ul style="list-style-type: none"> <li>Number of mobile clinic and outreach events offering Paps each year.</li> <li>Number of patients with insurance coverage each year.</li> <li>Scheduling and care coordination policies developed.</li> <li>Number of patients that receive follow up for positive screening tests.</li> <li>Number of policies reviewed annually and amended as needed.</li> <li>Number of visits with risk assessments, education and health promotion counseling for Pap and mammograms included.</li> </ul>
	Increase public awareness on the importance of regular checkups and preventative screenings such as Pap	<ul style="list-style-type: none"> <li>-Review existing educational materials and ensure they are culturally and linguistically appropriate.</li> <li>-Use mass and small media to promote women’s</li> </ul>	Number of educational materials reviewed/developed.

**DOMAIN: Women/Maternal Health****PRIORITY: Improve women's health through cervical and breast cancer and anemia screening.****NOM: Low birth weight rate (%)****Pre-term birth rate (%)****NPM #1: Increase women receiving a well woman visit including Pap and mammogram.**

Objectives	Strategies	Key Activities	Evaluation
	and mammograms	<p>preventive screening, provide appointment reminders, etc.</p> <p>-Include effective campaign strategies to increase Pap and mammogram screenings in the month long CNMI Women's Health Month activities.</p> <p>-Maintain partnerships with governmental, advocacy and community organizations to assure the availability of quality patient and public education materials, campaigns, and programs on women's preventive screenings.</p>	<p>Number of patients that receive preventive screenings and schedule follow up appointments.</p> <p>Identified effective campaign strategies; number of campaigns during CNMI Women's Health month promoting Pap and mammogram screenings.</p> <p>MOUs developed with partners; number of statewide resources identified.</p>

**DOMAIN: Women/Maternal Health****PRIORITY: Improve women's health through cervical and breast cancer and anemia screening.****NOM: Low birth weight rate (%)****Pre-term birth rate (%)****SPM #1: Increase pregnant women screened for anemia.**

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase number of pregnant women screened for iron anemia by 10% of all pregnancies.	Integrate components of preconception health, including anemia screenings and other preventive screenings, into existing services/standard of care for pregnant women.	<p>-Maintain and strengthen partnerships to develop comprehensive systems of care for pregnant women.</p> <p>- Include preconception care education in the WIC Group Prenatal Care curriculum.</p> <p>-Enhance administrative services such as improving scheduling and care coordination of pregnant women.</p>	<p>MOUs developed detailing responsibilities.</p> <p>Number of patients receiving preconception care counseling.</p> <p>Scheduling and care coordination policies developed.</p>

**DOMAIN: Women/Maternal Health****PRIORITY: Improve women's health through cervical and breast cancer and anemia screening.****NOM: Low birth weight rate (%)****Pre-term birth rate (%)****SPM #1: Increase pregnant women screened for anemia.**

Objectives	Strategies	Key Activities	Evaluation
		<ul style="list-style-type: none"> <li>-Maintain partnership with the CHCC Women's Clinic, with a focus on improving access to and quality of primary care (i.e. preconception health care screening and follow-up)</li> <li>-Maintain partnership with CHCC Women's Clinic to review existing screening policies and procedures and amend if necessary.</li> <li>- Advocate for Medicaid and Private Insurance coverage to improve financing of preconception health care services.</li> <li>-Maintain partnership with all public and private clinics to include as a part of the well woman visit, risk assessments and education and health promotion counseling for anemia screenings.</li> <li>-Evaluate the capacity of ICare case management software to measure the impact of preconception services for pregnant women.</li> </ul>	<p>Documentation of integrated/improved efforts; preconception health included in standard of care.</p> <p>Policies reviewed annually and amended as necessary.</p> <p>Number of patients with insurance coverage.</p> <p>Number of visits with risk assessments, education and health promotion counseling for anemia screenings included.</p> <p>Software fully implemented and measures identified.</p>
	<p>Increase public awareness on the importance of regular checkups and preventative screenings such as anemia screenings.</p>	<ul style="list-style-type: none"> <li>-Review existing educational materials and ensure they are culturally and linguistically appropriate.</li> <li>-Improve preconception care awareness in the villages and outlying clinics.</li> <li>-Use mass and small media to promote women's preventive screening, provide appointment reminders, etc.</li> </ul>	<p>Number of educational materials that are culturally and linguistically appropriate.</p> <p>Number of awareness campaigns in villages and outlying clinics.</p> <p>Number of patients that receive preventive screenings and schedule follow up appointments.</p>

**DOMAIN: Women/Maternal Health****PRIORITY: Improve women’s health through cervical and breast cancer and anemia screening.****NOM: Low birth weight rate (%)****Pre-term birth rate (%)****SPM #1: Increase pregnant women screened for anemia.**

Objectives	Strategies	Key Activities	Evaluation
		-Include effective campaign strategies to increase anemia screenings in the month long CNMI Women’s Health activities.  -Maintain partnerships with governmental, advocacy and community organizations to assure the availability of quality patient and public education materials, campaigns, and programs on women’s preventative screenings.	Identified effective campaign strategies; number of campaigns during CNMI Women’s Health month promoting anemia screenings.  Documentation of integrated efforts; Number of partners that provide public education material, campaign, and/or programs on women’s preventative screenings.

**Perinatal/Infant Health**

With the priority to improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep, the Maternal and Child Health Bureau (MCHB) anticipates aligning efforts per this measure, by reporting year 2017, with activities already identified by the CNMI Infant Mortality (IM) Collaborative Improvement and Innovation Network (CoIIN) Team. MCHB also intends to continue collaboration with the CNMI Women, Infant and Children (WIC) Program and the Commonwealth Healthcare Corporation’s (CHCC) Women’s Clinic in regards to activities already in place per the promotion of breastfeeding and prenatal care. Key activities identified and underway by MCHB that support this measure are the updating of its Memorandum of Understanding (MOU) with the State Medicaid Office to include the processing and expediting of MCH client applications and the funding for Labor & Delivery nurses to receive off-island training on lactation and support.

To ensure that such measure is collected and tracked, MCHB, through collaboration with the State Systems Development Initiative (SSDI) Program, will incorporate the data field for this measure into its Title V Data Repository System. MCHB will design and implement a Plan-Do-Study-Act (PDSA) model to improve MCHB outreach educational efforts. MCHB will work closely with the WIC Program and Title V Epidemiologist when designing its quality assurance and improvement process.

Implementation and evaluation on key activities detailed for the priority identified in this domain will rely heavily on coordinated efforts with partners and key stakeholders. Evaluation on key activities and their successes and/or shortcomings will be done through utilizing and identified PDSA model. Improvement made in health indicators of this domain will be demonstrated through an increase in the number of those who report exclusive breastfeeding, practicing safe sleep

habits, and obtaining early and adequate prenatal care.

**DOMAIN: Infant/Perinatal Health**

**PRIORITY:** Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep.

**NOM:** Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Sleep-related SUID per 1,000 live births

**NPM #4: Increase women reporting exclusive breastfeeding through 6 months.**

Objectives	Strategies	Key Activities	Evaluation
<p>By 2020, increase the percent of WIC mothers reporting exclusive breastfeeding by 30%.</p>	<p>Increase referrals to WIC Breastfeeding Peer Counselor(s).</p>	<ul style="list-style-type: none"> <li>- Include information about the WIC Breastfeeding (BF) Peer Counselor Program in Group Prenatal Care curriculum.</li> <li>-Refer new moms enrolled in the HOME Visiting Program to WIC Breastfeeding Peer Counselor(s).</li> <li>-Maintain partnership with CHCC L&amp;D Unit to increase referrals to WIC Breastfeeding Peer Counselor Program.</li> <li>-Develop reporting systems for referrals.</li> <li>-Identify current referral systems and their effectiveness.</li> </ul>	<p>BF Peer Counselor Program included in Group Prenatal Care curriculum.</p> <p>Number of HOME Visiting Program moms that accessed services from WIC’s BF Peer Counselor(s).</p> <p>Number of patients referred to the WIC BF Peer Counselor Program by the CHCC L&amp;D Unit.</p> <p>Fully functional referral and tracking system. Evaluation report on current referral system completed.</p>
<p>By 2020, increase the number of hospital that achieve baby friendly status from 0 to 1.</p>	<p>Implement the ten (10) Steps to Successful Breastfeeding.</p>	<ul style="list-style-type: none"> <li>-Identify necessary trainings for hospital to become baby friendly and how to implement the ten (10) steps.</li> <li>-Meet with CHCC management to discuss baby friendly initiative and ten (10) steps.</li> <li>-Maintain partnership with WIC to provide assistance in achieving baby friendly status.</li> </ul>	<p>Number of necessary trainings identified.</p> <p>Documentation of integrated effort (i.e. number of meetings, meeting minutes, agenda, sign-in sheets).</p> <p>MOU with WIC developed identifying roles and responsibilities in achieving baby friendly status.</p>

**DOMAIN: Infant/Perinatal Health****PRIORITY:** Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep.**NOM:** Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Sleep-related SUID per 1,000 live births

**NPM #4: Increase women reporting exclusive breastfeeding through 6 months.**

Objectives	Strategies	Key Activities	Evaluation
By 2020, number of trainings on breastfeeding and lactation for health professionals at CHCC will increase from baseline.	Increase opportunities for evidence based trainings on breastfeeding and lactation.	<ul style="list-style-type: none"> <li>-Maintain partnership with CNMI CollIN Committee and other stakeholders to identify and develop continuing education.</li> <li>-Collaborate with OB/GYN Department Chair to ensure that continuing education on breastfeeding and human lactation is provided annually.</li> <li>-Identify online resources for continuing education.</li> </ul>	<p>Continuing Education Plan on breastfeeding and lactation developed.</p> <p>Number of health professionals at CHCC that receive annual training on breastfeeding and lactation.</p> <p>Number of online resources identified for continuing education.</p>

**DOMAIN: Infant/Perinatal Health****PRIORITY:** Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep.**NOM:** Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Sleep-related SUID per 1,000 live births

**NPM #5: Increase mothers reporting they most often place the baby on its back to sleep in a separate sleep area.**

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase the number of HOME Visiting mothers reporting they most often place the baby on its back to sleep in a safe, separate	Implement Safe to Sleep Assessment Tool in HOME Visiting curriculum.	<ul style="list-style-type: none"> <li>-Include assessment of a designated, safe baby sleep area within the program's Child Information Form being completed by Family Partner Advocates.</li> <li>-Assist families in creating goal plans for obtaining cribs or pack and plays that are safe sleep approved for those that do not have a designated, safe baby sleep area.</li> </ul>	<p>Number of assessments completed by Family Partner Advocates.</p> <p>Number of goals plans created.</p>

**DOMAIN: Infant/Perinatal Health**

**PRIORITY:** Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep.

**NOM:** Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Sleep-related SUID per 1,000 live births

**NPM #5: Increase mothers reporting they most often place the baby on its back to sleep in a separate sleep area.**

Objectives	Strategies	Key Activities	Evaluation
area.		<ul style="list-style-type: none"><li>-Collaborate with the Cribs for Kids organization to bring safe sleep approved cribs and/or pack and plays to the CNMI so that they are available and affordable.</li><li>-Develop reporting systems for referrals.</li></ul>	<p>Documentation of integrated efforts; number of cribs and/or pack and plays obtained through Cribs for Kids.</p> <p>Fully functional referral and tracking system.</p>
By 2020, a Safe Sleep Policy will be developed and distributed statewide.	Develop a written policy that describes the practices to be used to promote safe sleep.	<ul style="list-style-type: none"><li>-Research safe sleep practices recommended by the AAP.</li><li>-Meet with CHCC management and providers to develop policy.</li><li>-Distribute policy to all key stakeholders.</li><li>-Maintain partnership with WIC, HOME Visiting, other key stakeholders, and providers to ensure Safe Sleep Policy is reviewed annually and updated as necessary.</li></ul>	<p>AAP approved Safe Sleep practices identified.</p> <p>Safe Sleep Policy developed.</p> <p>Number of key stakeholders that disseminate/provide information on Safe Sleep practice identified in the policy.</p> <p>Documentation of integrated effort; Annual review of Safe Sleep Policy and updated as needed.</p>

**DOMAIN: Infant/Perinatal Health**

**PRIORITY:** Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep.

**NOM:** Infant mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Sleep-related SUID per 1,000 live births

**SPM #: Increase early and adequate prenatal care women receiving prenatal care beginning in first trimester stratified by insurance.**

Objectives	Strategies	Key Activities	Evaluation
<p>By 2020, increase the number of women receiving prenatal care beginning in first trimester by 10%.</p>	<p>Reduce barriers to prenatal care by improving access to services.</p>	<ul style="list-style-type: none"> <li>-Offer prenatal care in mobile clinic, community health centers, and other non-traditional sites (i.e. NAP, WIC, and Village Centers).</li> <li>-Investigate sources of care for pregnant women who are uninsured or underinsured, including providers that offer payment options.</li> <li>-Enhance administrative services such as improving scheduling and care coordination.</li> <li>-Maintain partnership with the CNMI WIC, with a focus on improving prenatal care for WIC participants enrolled in Group Prenatal Care.</li> <li>-Maintain partnership with CHCC Women’s Clinic to promote provider’s adherence to ACOG guidelines pertaining to first trimester entry to prenatal care.</li> <li>-Maintain partnership with all public and private clinics to include as a part of the well woman visit, risk assessments and education and health promotion counseling for preconception and inter-conception care.</li> <li>-Evaluate the capacity of ICare case management software to measure the impact of preconception services for pregnant women.</li> </ul>	<p>Number of mobile clinic and outreach events offering prenatal care each year.</p> <p>Resource guide/list of providers who offer services to pregnant women who are either uninsured or underinsured with information on payment options developed.</p> <p>Scheduling and care coordination policies developed.</p> <p>Number of WIC participants that receive early and adequate prenatal care.</p> <p>Number of CHCC Women’s Clinic Providers that adhere to the ACOG guidelines.</p> <p>Number of visits with risk assessments, education and health promotion counseling for preconception care and inter-conception care completed.</p> <p>Software fully implemented and measures identified.</p>
	<p>Educate community on the availability of prenatal care resources, insurance</p>	<ul style="list-style-type: none"> <li>-Review existing educational materials and ensure they are culturally and linguistically appropriate.</li> </ul>	<p>Number of educational materials that are culturally and linguistically appropriate.</p>

**DOMAIN: Infant/Perinatal Health**

**PRIORITY:** Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep.

**NOM:** Infant mortality rate per 1,000 live births  
Post neonatal mortality rate per 1,000 live births  
Sleep-related SUID per 1,000 live births

**SPM #: Increase early and adequate prenatal care women receiving prenatal care beginning in first trimester stratified by insurance.**

Objectives	Strategies	Key Activities	Evaluation
	eligibility, and other support services.	<ul style="list-style-type: none"><li>-Improve preconception care awareness in the villages and outlying clinics.</li><li>-Use social media to promote early and adequate prenatal care campaign.</li><li>-Include effective campaign strategies to increase early and adequate prenatal care in the month long CNMI Women's Health activities.</li><li>-Maintain partnerships with governmental, advocacy and community organizations to assure the availability of quality patient and public education materials, campaigns, and programs on early and adequate prenatal care.</li></ul>	<ul style="list-style-type: none"><li>Number of awareness campaigns in villages and outlying clinics.</li><li>Number of pregnant women that receive early and adequate prenatal care.</li><li>Number of activities during Women's Health Month that promote early and adequate prenatal care.</li><li>Documentation of integrated efforts; Number of partners that provide public education material, campaign, and/or programs on early and adequate prenatal care.</li></ul>

**Children's Health**

With the priority to improve child health through providing vaccinations and screening for developmental delays, the Maternal and Child Health Bureau (MCHB) looks towards continuing its efforts, through the Early Childhood Comprehensive Services (ECCS) Program, of having the Ages and Stages Questionnaire (ASQ)-3 developmental screening tool administered at the Commonwealth Healthcare Corporation's (CHCC) Children's Clinic and participating privately-owned infant and child daycare centers. MCHB will also continue its collaboration with the CNMI-Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, the Healthy Outcomes for Maternal and Early-childhood (H.O.M.E.) Visiting Program. The H.O.M.E. Visiting Program, under MCHB, administers both the ASQ-3 and ASQ:SE development screenings with all children and families voluntarily enrolled in the program. MCHB anticipates aligning and strengthening its program efforts with the CHCC Immunization Program, such as through identifying and helping to improve access for children and families in need of vaccinations, as well as continuously receiving Title V data related to the Immunization Program. Additionally, MCHB will work closely with the Immunization

Program on receiving new required data such as with seasonal influenza, the HPV vaccine, the Tdap vaccine and the meningococcal conjugate vaccine. All new required data fields will be incorporated into the Title V Data Repository System.

MCHB will continue to work closely with the State Systems Development Initiative (SSDI) Program to make certain that all required data elements, as part of the five-year reporting cycle, are collected and tracked, such as with the vaccinations. Collaboration between all departments will not only include data sharing but also on strategic planning and activities designed to achieve improving such measure. As a mechanism to evaluating such measure’s success/deficiency, in regards to proposed activities, MCHB will implement a Plan-Do-Study-Act (PDSA) evaluation done through monitoring data and outcomes regularly as part of a short cycle Performance Improvement.

A PDSA cycle of testing will be completed to evaluate the overall effectiveness of key activities identified for each strategy. Improvement in this domain will rely heavily on coordinated efforts through existing partnerships and in light of this, MCHB has indicated the enhancement or strengthening of partnerships as a key strategy in meeting its objective.

**DOMAIN: Children’s Health**  
**PRIORITY: Improve child health through providing vaccinations and screening for developmental delays.**  
**NOM: Percent of children meeting the criteria developed for school readiness.**

**NPM #6: Increase children receiving developmental screening.**

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase the proportion of young children who are screened, evaluated, and enrolled in special services in a timely manner from baseline to 25%, 5% each year.	Implement the Ages and Stages Questionnaire tools at all CHCC satellite clinics.	<ul style="list-style-type: none"> <li>- Implement ASQ SOPs for each clinic site which includes the agreed upon quality components for each of the following essential roles: surveillance, screening, referral, evaluation, parent education, and support.</li> <li>- Evaluate capacity of the Electronic Health Record (EHR) Well Child Module to be used as a mechanism for electronic data capture, validation, analysis and reporting of ASQ results.</li> </ul>	<p>Number of clinics that administer the ASQ questionnaire.</p> <p>Evaluation report of EHR and its suitability in managing developmental screening data completed.</p>
	Enhance partnerships with community by developing a partnership document that outlines function and partner roles and responsibilities to ensure increased	<ul style="list-style-type: none"> <li>- Meet with ECCS partners to identify roles, responsibilities, and strategies towards a coordinated approach in integrating program services to ensure screenings, referrals, evaluations, and connecting those in need to services they are eligible for.</li> </ul>	MOU developed detailing roles, responsibilities, and strategies of all partners involved.

**DOMAIN: Children's Health****PRIORITY:** Improve child health through providing vaccinations and screening for developmental delays.**NOM:** Percent of children meeting the criteria developed for school readiness.**NPM #6: Increase children receiving developmental screening.**

Objectives	Strategies	Key Activities	Evaluation
	screenings for developmental delays	- Develop data and benchmark monitoring report to be assessed as part of regular partnership meetings.	Data plan completed detailing identified measures and frequency of reporting.

**DOMAIN: Children's Health****PRIORITY:** Improve child health through providing vaccinations and screening for developmental delays.**NOM:** Percent of children meeting the criteria developed for school readiness.**SPM #3: Increase children receiving routine vaccines.**

Objectives	Strategies	Key Activities	Evaluation
By 2020, increase the percent of children 0 to 18 receiving routine vaccines by 10%.	Partner with Immunization's Vaccines for Children Program to improve access to vaccines for children.	<ul style="list-style-type: none"> <li>- Include information about VFC Program in Group Prenatal Care curriculum.</li> <li>-Refer new moms enrolled in the HOME Visiting Program to VFC Program.</li> <li>-Maintain partnership with CHCC L&amp;D Unit to increase referrals to VFC Program.</li> <li>-Develop reporting systems for referrals.</li> <li>-Identify current referral systems and their effectiveness.</li> </ul>	<ul style="list-style-type: none"> <li>VFC Program included in Group Prenatal Care curriculum.</li> <li>Number of HOME Visiting Program moms that access services through the VFC Program.</li> <li>Number of families referred to the VFC Program by the CHCC L&amp;D Unit.</li> <li>Fully functional referral and tracking system.</li> <li>Evaluation report of the current referral system completed.</li> </ul>

## Adolescent Health

With the priority to improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide), the Maternal and Child Health Bureau (MCHB) anticipates planning and implementing, by reporting year 2017, culturally appropriate evidence-based activities aimed at reducing risk behaviors and poor outcomes for adolescents. Activities anticipated include a curriculum facilitated type outreach addressing bullying and substance abuse and the use of the Commonwealth Healthcare Corporation's (CHCC) mobile clinic to conduct and provide preventive counseling and support and health outreach. MCHB will establish a Memorandum of Understanding (MOU) between the CNMI Public School System/Private Schools and the Division of Public Health Services - MCHB. Meanwhile, activities and efforts already undertaken by MCHB that support such measure include the filming of TV commercials aimed at highlighting statistics and consequences of teen pregnancies, establishing relationships with various high schools and the Northern Marianas College as a way to gain input and understanding on the current trends of risky behaviors practiced by adolescents in the CNMI, as well as producing radio advertisements regarding teen pregnancy.

To ensure that such measure is collected and tracked, MCHB through collaboration with the State Systems Development Initiative (SSDI) Program, will incorporate the data field for this measure into its Title V Data Repository System. Furthermore, MCHB will implement quality assurance and will use a Plan Do Study Act (PDSA) Quality Improvement to make such improvements.

Results on PDSA cycle quality assurance for each strategy identified will be the basis in evaluating key activities outlined in this domain. In addition to gathering data through the state's Title V Data Repository System, information from the CNMI Public School System's (PSS) Youth Risk Behavior Survey (YRBS) will be analyzed to determine whether impact was demonstrated in the identified priority area.

**DOMAIN: Adolescent Health**

**PRIORITY:** Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).

**NOM:** Adolescent mortality ages 10 through 19 per 100,000.

Adolescent suicide ages 15 through 19 per 100,000.

**NPM #9: Decrease adolescents bullying.**

Objectives	Strategies	Key Activities	Evaluation
By 2020, reduce the number of students who reported being bullied at school by 10%.	Develop a comprehensive school-health approach to address health and safety issues, including bullying and cyberbullying.	<ul style="list-style-type: none"> <li>-Secure and maintain administrative support and commitment by developing a MOU between MCH and PSS's Teen Talk Program.</li> <li>-Partner with PSS Teen Talk Program to establish a school health advisory council to address bullying and other risk</li> </ul>	<ul style="list-style-type: none"> <li>MOU between MCH and PSS' Teen Talk Program completed.</li> <li>School health advisory council members identified and council is formally established.</li> </ul>

**DOMAIN: Adolescent Health**

**PRIORITY:** Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).

**NOM:** Adolescent mortality ages 10 through 19 per 100,000.

Adolescent suicide ages 15 through 19 per 100,000.

**NPM #9: Decrease adolescents bullying.**

Objectives	Strategies	Key Activities	Evaluation
		<p>behaviors.</p> <ul style="list-style-type: none"> <li>-Partner with PSS Teen Talk Program to develop a plan which would be incorporated into a school's overall improvement plan to link health with learning outcomes.</li> <li>-Partner with PSS Teen Talk Program to implement policies and programs to address health-risk behaviors.</li> <li>-Provide support for continuing education essential for teachers, administrators, and others included in school health approach to address adolescent risk behaviors.</li> </ul>	<p>Number of schools that have amended their improvement plan to link health with learning outcomes.</p> <p>Number of schools implementing policies and/or programs to address health-risk behaviors.</p> <p>Number of public school staff attending training and/or professional development in addressing adolescent risk behaviors.</p>
	<p>Provide opportunities for students to be meaningfully involved in the school and the community.</p>	<ul style="list-style-type: none"> <li>-Partner with Youth Affairs Office to establish a cross-age mentoring program in the community youth centers.</li> <li>-Partner with sports associations to promote positive social interactions.</li> <li>-Maintain partnerships with governmental, advocacy and community organizations to assure the availability of volunteer opportunities/after school programs for students to engage in peer education and peer advocacy programs aimed at curving risk behaviors, including bullying.</li> </ul>	<p>Number of youth centers implementing mentoring programs.</p> <p>Number of sporting events available to adolescents throughout the year.</p> <p>Number of volunteer opportunities and/or after school programs available throughout the year.</p>
	<p>Expand options for</p>	<ul style="list-style-type: none"> <li>-Establish a reporting tool/anti bullying hotline that is user</li> </ul>	<p>Hotline established and fully operational.</p>

**DOMAIN: Adolescent Health**

**PRIORITY:** Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).

**NOM:** Adolescent mortality ages 10 through 19 per 100,000.

Adolescent suicide ages 15 through 19 per 100,000.

**NPM #9: Decrease adolescents bullying.**

Objectives	Strategies	Key Activities	Evaluation
	adolescents to report bullying incidences.	friendly; features include mass alert system for those that need to take action.  -Maintain partnerships with school counselors to encourage students to utilize hotline.	Number of calls to the hotline related to bullying.

**DOMAIN: Adolescent Health**

**PRIORITY:** Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).

**NOM:** Adolescent mortality ages 10 through 19 per 100,000.

Adolescent suicide ages 15 through 19 per 100,000.

**SPM #: Decrease adolescent suicide.**

Objectives	Strategies	Key Activities	Evaluation
By 2020, decrease adolescent suicide rates by 10%.	Develop a comprehensive school-health approach to improve health and safety poor outcomes, including suicide.	Secure and maintain administrative support and commitment by developing a MOU between MCH and PSS's Teen Talk Program.  -Partner with PSS Teen Talk Program to establish a school health advisory council to prevent suicide.  -Partner with PSS Teen Talk Program to develop a plan which would be incorporated into a school's overall improvement plan to link health with learning outcomes.  -Partner with PSS Teen Talk Program to implement policies and programs to address health-risk behaviors and poor	MOU between MCH and PSS' Teen Talk Program completed.  School health advisory council members identified and council is formally established.  Number of schools who have amended their improvement plan to link health with learning outcomes.  Number of schools implementing policies

**DOMAIN: Adolescent Health**

**PRIORITY:** Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).

**NOM:** Adolescent mortality ages 10 through 19 per 100,000.

Adolescent suicide ages 15 through 19 per 100,000.

**SPM #: Decrease adolescent suicide.**

Objectives	Strategies	Key Activities	Evaluation
		<p>outcomes.</p> <p>-Provide support for continuing education essential for teachers, administrators, and others included in school health approach.</p>	<p>and/or programs to address health-risk behaviors.</p> <p>Number of public school staff attending training and/or professional development in addressing adolescent risk behaviors.</p>
	<p>Enhance partnerships and collaboration between and among public and private entities that have made a commitment to public awareness of suicide and suicide prevention.</p>	<p>-Review existing educational materials and ensure they are culturally and linguistically appropriate.</p> <p>- Identify available counseling resources for at-risk youth to access.</p> <p>-Improve suicide and suicide prevention awareness in the schools and youth centers.</p> <p>-Use social media to increase awareness of suicide and suicide prevention.</p> <p>-Develop effective campaign strategies to prevent suicides and disseminate among partners.</p>	<p>Number of educational materials that are culturally and linguistically appropriate.</p> <p>Resource guide detailing available counseling services completed.</p> <p>Number of schools and youth centers providing/disseminating suicide prevention information.</p> <p>Number of suicide prevention information/material posted on social media outlets.</p> <p>Number of partners that receive information on strategies to prevent suicides.</p>
<p>By 2020, annual reports on Youth Suicide will be available to help</p>	<p>Enhance the quality and quantity of data available on suicide and suicidal behavior.</p>	<p>-Partner with Child/Youth Mortality Committee to improve analysis and availability of child death review data.</p> <p>-Partner with CHCC coders to improve the coding for</p>	<p>Documentation of integrated efforts, i.e. agenda, meeting minutes, sign- in sheets.</p> <p>Matrix of codes on external cause of injuries</p>

**DOMAIN: Adolescent Health**

**PRIORITY:** Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).

**NOM:** Adolescent mortality ages 10 through 19 per 100,000.

Adolescent suicide ages 15 through 19 per 100,000.

**SPM #: Decrease adolescent suicide.**

Objectives	Strategies	Key Activities	Evaluation
establish local program priorities necessary for evaluating the impact of suicide prevention strategies.		external cause of injuries.  -Partner with DPHS/MCHB Epidemiologist to pilot a project to link and analyze information on self-destructive behavior from existing data systems.	developed.  Initial analytical review on self-destructive behavior completed.

**DOMAIN: Adolescent Health**

**PRIORITY:** Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).

**NOM:** Adolescent mortality ages 10 through 19 per 100,000.

Adolescent suicide ages 15 through 19 per 100,000.

**SPM: Decrease teen pregnancy rates among 13-14 and 15-17 year olds.**

Objectives	Strategies	Key Activities	Evaluation
By 2020, decrease teen pregnancy rates by 10%.	Develop a comprehensive school-health approach to improve health and safety poor outcomes, including suicide.	-Secure and maintain administrative support and commitment by developing a MOU between MCH and PSS's Teen Talk Program.  -Partner with PSS Teen Talk Program to establish a school health advisory council to address teen pregnancies.  -Partner with PSS Teen Talk Program to develop a plan which would be incorporated into a school's overall improvement plan to link health with learning outcomes.	MOU between MCH and PSS' Teen Talk Program completed.  School health advisory council members identified and council is formally established.  Number of schools that have amended their improvement plan to link health with learning outcomes.

**DOMAIN: Adolescent Health**

**PRIORITY:** Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide).

**NOM:** Adolescent mortality ages 10 through 19 per 100,000.

Adolescent suicide ages 15 through 19 per 100,000.

**SPM: Decrease teen pregnancy rates among 13-14 and 15-17 year olds.**

Objectives	Strategies		Evaluation
		-Partner with PSS Teen Talk Program to implement policies and programs to address health-risk behaviors and poor outcomes.  -Provide support for continuing education essential for teachers, administrators, and others included in school health approach.	Number of schools implementing policies and/or programs to address health-risk behaviors.  Number of public school staff attending training and/or professional development in addressing adolescent risk behaviors.
	Establish a community, evidence-based Teen Pregnancy Prevention Program.	-Review existing programs and ensure they are culturally and linguistically appropriate.  -Identify a program that is effective in reducing teen pregnancy, sexually transmitted infections, and behavioral risks that fits the needs of the community.  -Maintain partnerships with governmental, advocacy and community organizations to assure participation and buy-in of Teen Prevention Program.	Report detailing a review of existing programs completed.  Prevention program implemented.  Number of organizations that take part in Teen Prevention Program activities.

**Children with Special Health Care Needs:**

In the CNMI, birth defects are a leading cause of infant mortality, accounting for 40% of all infant deaths for years 2009 through 2014. Furthermore, birth defects in the CNMI, like most other places, are a leading contributor of long-term disability. In reporting year 2014, 43.5% of families with identified CSHCN reported not having adequate insurance coverage or no insurance coverage at all. Thus, accessing specialized services for long-term disability or care associated with CSHCN becomes a hindrance for families with identified CSHCN. Evidence-based strategies are needed in order to identify and provided identified CSHCN and their families with continuous quality care. The CNMI will include a range of strategies to provide improved and quality care including 1) establishing medical homes for identified CSHCN; 2) advocating for improved coverage for CSHCN; 3) developing a state-wide/"universal" comprehensive care plan for all CSHCN;

4) reinstating the CNMI Birth Defects Registry; and 5) reinstating the Newborn Screening at CHCC.

With the priority to provide a medical home for children identified as Children with Special Health Care Needs, the Maternal and Child Health Bureau (MCHB) CSHCN Program, identify a medical home for all children with and without special health care needs who seek their program services. While there are many barriers that prevent CSHCN and their families from establishing a medical home, insurance coverage remains as one of the principal problem. In efforts to supports this measure the CSHCN Coordinator processes and expedites all new or renewal Medicaid applications of those enrolled in the CSHCN Program. MCHB has recently updated its Memorandum of Understanding (MOU) between the State Medicaid Office and the Division of Public Health Services (DPHS) – MCHB to include amongst other data sharing services, the allowance of MCHB to receive, review, and submit MCH client’s Medicaid application for processing, and furthermore, to expedite the processing of MCH such applications. MCHB anticipates that the provision of the updated MOU will allow CSHCN, who qualify for Medicaid or are current Medicaid recipients, be able to establish a medical home. For all CSHCN, the CSHCN Program on setting effective program activities that link CSHCN and their families to a medical home, if not already having one.

Furthermore, to improve the identification of CSHCN through screening for developmental delays, the Maternal and Child Health Bureau (MCHB) CSHCN Program will continue to work closely with the Commonwealth Healthcare Corporation’s (CHCC) Children’s Clinic and participating privately-owned infant and child daycare centers who currently administer the developmental screening tool ASQ:3. MCHB and the CSHCN Program will also work with the Healthy Outcomes for Maternal and Early-childhood (H.O.M.E.) Visiting Program who administers both the ASQ-3 and ASQ:SE development screenings with all children and families voluntarily enrolled in the program. MCHB will make certain that all programs involved update its sharing agreements. MCHB, by reporting year 2017, will ensure that the CSHCN database will be modified and updated to link with CHCC’s EHR and RPMS systems so that all required data fields are made available, in terms of this measure, and that the CSHCN Program is able to identify and track CSHCN who may not otherwise qualify for services under the Early Intervention Services (EIS) Program, Early Hearing Detection and Intervention (EHDI) Program, and/or Shriner’s, but does have a specific health care need (i.e. asthma, hemophilia, etc.).

To ensure that such measure is collected and tracked, MCHB through collaboration with the State Systems Development Initiative (SSDI) Program, will incorporate the data field for this measure into its Title V Data Repository System. Furthermore, MCHB will work closely with all entities, including families, involved to develop an appropriate Plan Do Study Act (PDSA) cycle of testing to guide improvements which will rely heavily on coordinated data sharing and monitoring.

Impact made in the priority area identified in this domain will rely heavily on the overall success of the key activities outlined below. As a mechanism to evaluating such measure’s success/deficiency, in regards to proposed activities, MCHB will implement Plan-Do-Study-Act (PDSA) cycle of evaluation prior to whole implementation of activities. Involvement of key partners identified within the plan for the implementation and evaluation of key activities will be vital in determining successes or deficiencies.

**DOMAIN: Children with Special Health Care Needs**

**PRIORITY: Provide a medical home for children identified as Children with Special Health Care Needs.**

**NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%)**

**Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)**

**NPM #11: Increase Children with Special Health Care Needs with a medical home.**

Objectives	Strategies	Key Activities	Evaluation
<p>By 2020, increase number of identified CSHCN provided with a medical home by 10%.</p>	<p>Reduce barriers to establishing a medical home by improving access to services.</p>	<ul style="list-style-type: none"> <li>-Identify CSHCN with medical homes and provide linkage to medical homes for those without one in CHCC, Private Clinics, community health centers, and other non-traditional sites (i.e. NAP, WIC, and Village Centers).</li> <li>-Advocate for Medicaid and Private Insurance coverage for patients not otherwise eligible for such coverages.</li> <li>-Apply Participatory Action to guide developed policies and practices surrounding ensuring identified CSHCN have a medical home.</li> <li>-Enhance administrative services such as improving scheduling and care coordination.</li> <li>-Maintain partnership with the CHCC and Private Clinics, with a focus on enrolling identified CSHCN.</li> <li>-Maintain partnership with CHCC Children's Clinic to review existing screening policies and procedures that ensures CSHCN are current with health insurance coverage and amend if necessary to include automatic referral to MCHB Services Coordinator for insurance application assistance/processing.</li> <li>-Maintain partnership with all public and private clinics to include as a part of the well children visit a medical home assessment, insurance coverage/primary provider confirmation, and barriers to accessing a medical home checklist.</li> </ul>	<ul style="list-style-type: none"> <li>Number of outreach events each year offering medical home screenings and referrals for linkage to a medical home as needed.</li> <li>Number of identified CSHCN with adequate private and/or public insurance coverage each year.</li> <li>Number of identified CSHCN who receive coordinated ongoing comprehensive care within a family centered medical home.</li> <li>Number of CSHCN and their families who access necessary services and supports.</li> <li>Number of CSHCN who receive preventive and treatment health services within a medical home.</li> <li>Number of policies reviewed annually and amended as needed.</li> <li>Number of visits with risk assessments, education and medical home promotion for identified CSHCN included</li> </ul>

**DOMAIN: Children with Special Health Care Needs**

**PRIORITY: Provide a medical home for children identified as Children with Special Health Care Needs.**

**NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%)**

**Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)**

**NPM #11: Increase Children with Special Health Care Needs with a medical home.**

Objectives	Strategies	Key Activities	Evaluation
	Increase public awareness on the importance of establishing a medical home with a primary care provider.	<ul style="list-style-type: none"><li>-Review existing educational materials and ensure they are culturally and linguistically appropriate.</li><li>-Use mass and small media to promote the provision of medical homes for CSHCN, provide appointment reminders, etc.</li><li>-Work with CHCC, Private Clinics, and partner agencies, such as the Public School System-Special Education Program and the Community Guidance Center, to develop/ or adopt a position statement regarding ensuring that all identified CSHCN are provided with a medical home with the use of a state-wide comprehensive care plan.</li><li>-Maintain partnerships with governmental, advocacy and community organizations to assure the availability of quality patient and public education materials, campaigns, and programs on providing medical homes for identified CSHCN.</li></ul>	<ul style="list-style-type: none"><li>Number of educational materials reviewed/developed.</li><li>Number of identified CSHCN that are linked to a medical home and have schedule follow up appointments with an identified primary care provider.</li><li>MOU developed by all entities stating a shared position statement across agencies and use of universal comprehensive care plan for all identified CSHCN.</li><li>MOUs developed with partners; number of statewide resources identified.</li></ul>

**DOMAIN: Children with Special Health Care Needs**

**PRIORITY: Improve identification of Children with Special Health Care Needs through screening for developmental delay.**

**NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%)**

**Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)**

**Improve identification of Children with Special Health Care Needs through screening for developmental delays.**

**To be accomplished through NPM #6: Increase children receiving developmental screening.**

Objectives	Strategies	Key Activities	Evaluation
<p>By 2020, increase the proportion of CSHCN who are screened, evaluated, and enrolled in special services in a timely manner from baseline to 25%, 5% each year.</p>	<p>Implement the Ages and Stages (ASQ) Questionnaire tools at all CHCC satellite clinics.</p>	<ul style="list-style-type: none"> <li>- Implement ASQ SOPs for each clinic site which includes the agreed upon quality components for each of the following essential roles: surveillance, screening, referral, evaluation, parent education, and support.</li> <li>- Evaluate capacity of the Electronic Health Record (EHR) Well Child Module to be used as a mechanism for electronic data capture, validation, analysis and reporting of ASQ results.</li> </ul>	<p>Number of children screened early and continuously for special health care needs.</p> <p>Evaluation report of EHR and its suitability in managing developmental screening data completed.</p>
	<p>CNMI Birth Defects Registry reimplementaion</p>	<ul style="list-style-type: none"> <li>-Work with SSDI Program and CSHCN Program on the updated development of the Birth Defects Registry.</li> <li>-Work with CHCC, including its Laboratory, CSHCN Program and the CNMI CoIIN Team, to assure a continuous system of conducting newborn screening testing, shipping of specimens, ordering of kits, use of Birth Defects registry, sustainable funding, etc.</li> <li>- Partner with CHCC Nursery and Laboratory to offer Newborn Screening and referral for positive results.</li> </ul>	<p>Database developed with modules conformed to the requirements of Oregon State Public Health Laboratory/Northwest Regional Newborn Screening Program</p> <p>MOU developed upholding the vital role of the Birth Defects Registry in supporting child-find efforts for CSHCN.</p> <p>Number of newborns screened, identified, and referred timely to specialized services.</p>
	<p>Enhance partnerships with community by developing a partnership document that outlines function and partner roles and responsibilities to ensure increased screenings for developmental delays (i.e. how often will the Steering Committee will meet, minutes, partnership assessment tool discussed</p>	<ul style="list-style-type: none"> <li>- Meet with ECCS partners to identify roles, responsibilities, and strategies towards a coordinated approach in integrating program services to ensure screenings, referrals, evaluations, and connecting those in need to services they are eligible for.</li> <li>- Develop data and benchmark monitoring report to be assessed as part of regular partnership meetings.</li> </ul>	<p>MOU developed detailing roles, responsibilities, and strategies of all partners involved.</p> <p>Data plan completed detailing identified measures and frequency of reporting.</p>

**DOMAIN: Children with Special Health Care Needs**

**PRIORITY: Improve identification of Children with Special Health Care Needs through screening for developmental delay.**

**NOM: Children with Special Health Care Needs receiving care in a well-functioning system (%)**

**Children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations (%)**

**Improve identification of Children with Special Health Care Needs through screening for developmental delays.**

**To be accomplished through NPM #6: Increase children receiving developmental screening.**

Objectives	Strategies	Key Activities	Evaluation
	and agreed upon)		

**Cross Cutting**

With the priority to improve oral health of children and pregnant mothers, the Maternal and Child Health Bureau (MCHB) anticipates close collaboration with the Oral Health Program to align program efforts aimed at improving the number of children and pregnant mothers who come and seek dental services, by reporting year 2017. MCHB intends to strategize activities and services to include dental screenings and basic preventive services to be offered at the Commonwealth Healthcare Corporation's (CHCC) Women's Clinic, as well as at the CNMI Women, Infant and Children (WIC) Program. Culturally appropriate evidence-based activities will be researched for this measure.

Furthermore, with the priority to improve insurance status of children and pregnant mothers, the MCHB recently updated its Memorandum of Understanding (MOU) between the State Medicaid Office and the Division of Public Health Services (DPHS) – MCHB to include amongst other data sharing services, the allowance of MCHB to receive, review, and submit MCH client's Medicaid application for processing, and furthermore, to expedite the processing of MCH such applications. MCHB anticipates that the provision of the updated MOU will allow children, pregnant mothers, and families, who qualify for Medicaid or are current Medicaid recipients, be able to acquire and or remain coverage, with the end goal of establishing a medical home. Topics for such strategies include addressing the high cost of premiums associated with private insurance, in which insured families do not seek medical care altogether due to high costs. For this, MCHB intends to all seek guidance and work collaboratively with the CNMI government.

MCHB will continue to work closely with the State Systems Development Initiative (SSDI) Program to make certain that all required data elements, as part of the five-year reporting cycle, are collected and tracked, such as with the vaccinations. Collaboration between all departments will not only include data sharing but also on strategic planning and activities designed to achieve improving such measure. As a mechanism to evaluating such measure's success/deficiency, in regards to proposed activities, MCHB will implement a Plan-Do-Study-Act (PDSA) quality assurance model prior to wholesale implementation of activities.

**DOMAIN: Cross Cutting**

**PRIORITY:** Improve the health of all population domains by promoting oral health and improving insurance status of children and pregnant mothers.

**NOM:** Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months.

Percent of children without health insurance.

**NPM#13:** Increase the rate of women who had a dental visit during pregnancy and the rate of children ages 1 through 17 who had a preventative dental visit.

Objectives	Strategies	Key Activities	Evaluation
<p>By 2020, increase the rate of pregnant women who had a dental visit by 10%.</p>	<p>Integrate components of oral health care into existing services/standard of care for pregnant women.</p>	<ul style="list-style-type: none"> <li>-Maintain and strengthen partnerships with the Dental Clinic to develop comprehensive systems of care for pregnant women.</li> <li>- Include oral health care education in the WIC Group Prenatal Care curriculum.</li> <li>-Enhance administrative services such as improving scheduling and care coordination of pregnant women.</li> <li>-Maintain partnership with the CHCC Women’s Clinic, with a focus on improving access to and quality of primary care (i.e. oral health screening and follow-up)</li> <li>-Maintain partnership with CHCC Women’s Clinic to review existing screening policies and procedures and amend if necessary.</li> <li>-Maintain partnership with all public and private clinics to include as a part of prenatal visits, oral health assessments and education and health promotion counseling for oral health during pregnancy.</li> <li>-Evaluate the capacity of ICare case management software to measure the impact of oral health services for pregnant women.</li> </ul>	<p>MOUs developed detailing responsibilities.</p> <p>Number of patients receiving oral health care education/information.</p> <p>Scheduling and care coordination policies developed.</p> <p>Documentation of integrated/improved efforts; oral health care included in standard of care.</p> <p>Policies reviewed annually and amended as necessary.</p> <p>Number of visits of pregnant women with oral health education and promotion counseling included.</p> <p>Software fully implemented and measures identified.</p>
	<p>Increase public awareness</p>	<p>-Review existing educational materials and ensure they are</p>	<p>Number of educational materials</p>

**DOMAIN: Cross Cutting****PRIORITY:** Improve the health of all population domains by promoting oral health and improving insurance status of children and pregnant mothers.**NOM:** Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months.

Percent of children without health insurance.

**NPM#13: Increase the rate of women who had a dental visit during pregnancy and the rate of children ages 1 through 17 who had a preventative dental visit.**

Objectives	Strategies	Key Activities	Evaluation
	on the importance of oral health care during pregnancy.	<p>culturally and linguistically appropriate.</p> <p>-Use mass and small media to promote oral health care for pregnant women, provide appointment reminders, etc.</p> <p>-Include effective campaign strategies to increase oral health care for pregnant women in the month long CNMI Women's Health Month activities.</p> <p>-Maintain partnerships with governmental, advocacy and community organizations to assure the availability of quality patient and public education materials, campaigns, and programs on oral health care for pregnant women.</p>	<p>reviewed/developed.</p> <p>Number of prenatal patients that had an oral health screen completed.</p> <p>Identified effective campaign strategies; number of campaigns during CNMI Women's Health month promoting oral health care for pregnant women.</p> <p>MOUs developed with partners; number of statewide resources identified.</p>
By 2020, increase the rate of children ages 1 through 17 who had a preventative dental visit by 10%.	Establish partnerships with the CHCC Dental Clinic and private dental clinics to improve access to dental care.	<p>-Review existing educational materials and ensure they are culturally and linguistically appropriate.</p> <p>-Maintain and/or establish partnerships with public and private dental clinics to increase access to dental care.</p> <p>-Refer children enrolled in the HOME Visiting Program to dental providers.</p> <p>-Maintain partnership with all public and private clinics to include as a part of well child visits, oral health</p>	<p>Number of educational materials reviewed/developed.</p> <p>Number of partnering dental providers.</p> <p>Number of children enrolled in the HOME Visiting Program that had preventative dental visits.</p> <p>Number of well child visits with oral health education and promotion counseling</p>

**DOMAIN: Cross Cutting****PRIORITY:** Improve the health of all population domains by promoting oral health and improving insurance status of children and pregnant mothers.**NOM:** Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months.

Percent of children without health insurance.

**NPM#13:** Increase the rate of women who had a dental visit during pregnancy and the rate of children ages 1 through 17 who had a preventative dental visit.

Objectives	Strategies	Key Activities	Evaluation
		<p>assessments, education and oral health promotion counseling.</p> <p>-Maintain partnership with CHCC Children's Clinic and increase referrals for preventative dental visits.</p> <p>-Maintain partnership with the CHCC Children's Clinic and private providers, with a focus on improving access to preventative dental care.</p> <p>-Develop reporting systems for referrals.</p>	<p>included.</p> <p>Number of children referred by the CHCC Children's Clinic to a dental provider.</p> <p>Oral health assessments included in standard of care.</p> <p>Fully functional referral and tracking system.</p>
	<p>Establish a dental home for Children and Youth with Special Health Care Needs.</p>	<p>-Maintain and strengthen partnerships to develop comprehensive systems of care for CYSHCN.</p> <p>- Collaborate with the Public School System's Early Intervention (EIS) and Special Education (SPED) programs to include oral health as a component within their programs.</p> <p>- Partner with the EIS and SPED programs to increase referrals to the CHCC Dental Clinic.</p> <p>-Meet with CHCC management to discuss the establishment of a dental home for CYSHCN at the CHCC Dental Clinic.</p> <p>-Maintain partnership with public and private providers to facilitate referrals to the CHCC Dental Clinic for CYSHCN.</p>	<p>MOUs developed detailing responsibilities.</p> <p>Inclusion of an oral health component into the EIS and SPED programs.</p> <p>Number of referrals received from EIS and SPED programs.</p> <p>Policy or MOU completed establishing the CHCC Dental Clinic as a dental home for CYSHCN.</p> <p>MOUs developed detailing responsibilities.</p> <p>Number of referrals of CYSHCN to the</p>

**DOMAIN: Cross Cutting****PRIORITY:** Improve the health of all population domains by promoting oral health and improving insurance status of children and pregnant mothers.**NOM:** Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months.

Percent of children without health insurance.

**NPM#13: Increase the rate of women who had a dental visit during pregnancy and the rate of children ages 1 through 17 who had a preventative dental visit.**

Objectives	Strategies	Key Activities	Evaluation
		-Develop reporting systems for referrals.	CHCC Dental Clinic.  Fully functional referral and tracking system.

**DOMAIN: Cross Cutting****PRIORITY:** Improve the health of all population domains by promoting oral health and improving insurance status of children and pregnant women.**NOM:** Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months.

Percent of children without health insurance.

**NPM#15: Adequate insurance coverage (Percent of children ages 0 through 17 who are adequately insured).**

Objectives	Strategies	Key Activities	Evaluation
By 2020, decrease the rate of uninsured children and pregnant women by 20%	Improve access to Medicaid coverage by increasing community awareness of the Medicaid eligibility and application requirements.	-Maintain and strengthen partnership with CNMI Medicaid Office to improve access to Medicaid coverage for the populations served by MCHB.  -Develop and/or review existing Medicaid application materials/guide to ensure cultural and linguistic appropriateness.  -Maintain partnership with CHCC's L&D unit to ensure that all Medicaid insured or uninsured women seen at L&D are provided with information on accessing Medicaid coverage by providing application forms and guide.  - Provide guidance to partnering agencies on Medicaid eligibility and requirements.	Complete review and any necessary revision of MOU currently in place.  Culturally and linguistically appropriate Medicaid application forms and guide reviewed, revised, and/or developed.  Number of patients at the CHCC L&D unit that receive information on accessing Medicaid coverage.

**DOMAIN: Cross Cutting****PRIORITY:** Improve the health of all population domains by promoting oral health and improving insurance status of children and pregnant women.**NOM:** Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months.

Percent of children without health insurance.

**NPM#15: Adequate insurance coverage (Percent of children ages 0 through 17 who are adequately insured).**

Objectives	Strategies	Key Activities	Evaluation
	Improve access to Medicaid coverage by decreasing application processing time	- Assign MCHB personnel to assist clients in processing application forms.  -Maintain and strengthen partnerships with all partnering agencies that provide services to children and pregnant women to establish a system of identification and referral of all uninsured to Medicaid through MCHB.  -Develop reporting systems for referrals.	Number of partnering agency staff providing information on Medicaid eligibility and requirements.  Role and responsibility of assigned personnel established.  Number of referrals received through partnering agencies.  Fully functional referral and tracking system.

**Women/Maternal Health**

**Women/Maternal Health - Plan for the Application Year**

**Domain: Women's/Maternal Health**

**Plan for Application Year**

**Priority: Improve women's health through cervical and breast cancer screening and anemia screening.**

Goals/Objectives/Activities	Data/Evaluation	Program Staff Responsible
<b>Promote the importance of preventative screenings, including pap and mammogram screenings, for women of childbearing age in the CNMI</b>		
<b>Objectives: By 2017, increase number of women who received a Pap and Mammogram screenings by 2%</b>		
<b>Activity 1a.1:</b> Meet with key staff including Women's Clinic chairperson, Rota and Tinian Health Center staff) to identify strategies on building capacity to provide screening services	<ul style="list-style-type: none"> <li>• Number of meeting held</li> </ul>	MCHB, Breast & Cervical Cancer Early Detection Program
<b>Activity 1a.2:</b> Implement strategies identified	<ul style="list-style-type: none"> <li>• Implementation plan</li> </ul>	-MCHB, Breast & Cervical Cancer Early Detection Program, CHCC Women's Clinic
<b>Activity 1a.3:</b> Monitor breast and Cervical screening numbers in the CNMI	-CHCC Laboratory and Radiology Data	-MCHB, CHCC Laboratory, CHCC Radiology Department
<b>Activity 1a.4:</b> Provide MCHB and NCD Bureau staff with a tool to enhance knowledge and improve services delivery	-Training tool identified and used	-MCHB, NCD Bureau
<b>Activity 1a.5:</b> Revise program policies and procedures to address gaps to increase screening rates	-Number of policies reviewed and amended as needed	- MCHB, NCD Bureau
<b>Activity 1a.6:</b> Identify sites to conduct outreach and public education efforts	-Number of outreach events offering pap and mammogram	-MCHB, NCD Bureau

	screenings, including educational awareness	
<b>Goal 2: Promote the importance of anemia screenings for women of childbearing age in the CNMI</b>		
<b>Objectives: By 2017, established baseline for the number of women screened for anemia at CHCC.</b>		
<b>Activity 1b.1:</b> Maintain partnership with public and private clinics to include as part of the well woman visit, risk assessments and education and health promotion counseling for anemia screenings	- Number of visits with risk assessments, education and health promotion counseling for anemia screenings	-MCH, CHCC Women's Clinic, Private Clinics
<b>Activity 1b.1:</b> Identify effective campaign strategies to increase anemia screenings	-Evidence-based strategies identified	-MCH, MCH Epidemiologist
<b>Activity 1b.2:</b> Identify data system to measure anemia screenings	-Data system identified	-SSDI, MCH, MCH Epidemiologist
<b>Activity 1b.3</b> Review standard of care policies for all pregnant women and/or women of childbearing age at CHCC to include anemia screenings	-Number of policies reviewed and amended as needed	-MCH, CHCC
<b>Activity 1b.4:</b> Monitor and track anemia screenings for all pregnant women and women of childbearing age.	- Number of pregnant women and women of childbearing age that receive anemia screenings at CHCC	-SSDI, MCH, CHCC, Laboratory, MCH Epidemiologist
<b>Activity 1b.5:</b> Use mass and small media to promote women's preventive screening, such as with anemia screenings.	-Number of media campaigns relating to anemia screenings	-MCH

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**NPM 1 - Percent of women with a past year preventive medical visit**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	19	20	21	22	23

Family partnership is even more critical and considered in the delivery of healthcare services, especially since the CHCC became a semi-autonomous agency responsible for the primary and preventative health services for the community, especially the indigent. The funding cuts in local appropriations to the only public health system made it a necessity for the program to transform the MCH services and programs within the CHCC Division of Public Health Services. To align resources and improve effectiveness in all areas and programs serving the unique needs of the MCH population, priorities identified from the 2010 needs assessment guided MCH Program staff to focus efforts and available resources on activities to improve the health and well-being of women in the CNMI in 2014.

The integration of primary and public health initiatives has enhanced outreach events led by the CHCC DPHS. The division collaborates with providers to bring services into the villages. The MCH Program assisted with outreach events such as the Kagman Community Health Fair, Rota Health Symposium in one of the outer islands, Oral Health Cancer Awareness Month, and health awareness events held in 2014. During National Women’s Health Week (NWHW), the program partnered with providers including an obstetrician and a dentist to host daily health related events to promote women’s health. The program will continue to lead the events to highlight NWHW during the CNMI Women’s Health Month, which was expanded by the program into month long activities modeled after NWHW.

Future activities include continuous advertisements through different media outlets on the importance of being healthy before and throughout pregnancy, working with WIC on the fully launching the Centering Pregnancy initiative, and the use of the Mobile Clinic to reach out to the pocket of populations who present great barriers to accessing prenatal care, or any type health services. The life course framework will also be used to guide the program’s activities towards meeting the priorities and measures selected for this domain.

**NPM 18 - Top of Form**

**Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

NPM#18	2010	2011	2012	2013	2014
Performance Data	29.4	25.6	29.5	32.7	33.8

	2016	2017	2018	2019	2020
Annual Objective	43.0	45.0	48.0	51.0	54.0

**Interpretation of Performance Data (Form 10D):**

The percent of women receiving prenatal care in the first trimester continues to be adversely affected by the number of tourist deliveries that occur. These compromise one-third of all deliveries yet because of immigration limits, they are unable to come prior to the third trimester when they are due to deliver.

**Summary of Activities related to Performance Measure:**

In 2014 MCHB, alongside partnering agencies, has worked hard over the past year to increase awareness surrounding early prenatal and adequate care, preconception health, reproductive health, CNMI IM CoIIN (infant mortality awareness) initiatives, as well as increasing access to care by promoting Medicaid prenatal eligibility for non U.S. citizens. MCH Program recently updated its MOU with the State Medicaid Office to include, amongst other data sharing services, the allowance of MCH Program to receive, review, and submit MCH client's Medicaid application for processing, and furthermore, to expedite the processing of MCH client's Medicaid application. The MOU was updated as a result of collected data still indicating the low percentage of prenatal visits beginning in the first trimester, as well as the overall percentage of adequate prenatal care. Consequently, per this measure, there has been a 9.1 percentage increase over reporting year 2013.

Other strategies to meet the MCHB vision of healthy mothers, children, including children with special healthcare needs, and families in the CNMI included recruiting critical positions to improve and address the gaps in the program's workforce capacity including a MCH Epidemiology to improve data capacity and inform decision making at all levels, MCH Services Coordinator to assist with care coordination and eligibility services, Outreach Worker to reach a broader audience, and a Fiscal Specialist to manage overall accounting responsibilities of the programs within the Bureau. Improving access to health services by working closely with the Women's and Children's Clinics to evaluate services and provide support was another strategy the program used to improve overall CHCC performance in serving the community.

**Perinatal/Infant Health**

**Perinatal/Infant Health - Plan for the Application Year**

**Domain: Perinatal/Infant Health**

**Plan for Application Year**

**Priority: Improve perinatal/infant outcomes through early and adequate prenatal care services and promoting breastfeeding and safe sleep**

Goals/Objectives/Activities	Data/Evaluation	Program Staff Responsible
<b>Goal 1: Promote the importance of early and adequate prenatal care for women of childbearing age in the CNMI</b>		
<b>Objectives: By 2017, increase number of women receiving prenatal care beginning in the first trimester by 2%</b>		
<b>Activity 1c. 1:</b> Meet with key staff (including Women’s Clinic chairperson, Rota and Tinian Health Center staff) to identify strategies on building capacity to provide prenatal care services	-Number of meeting Held	-MCH, MCH Epidemiologist, CHCC Women’s Clinic, State Medicaid Office
<b>Activity 1c. 2:</b> Include preconception care education in the WIC Group Prenatal Care Curriculum	-Preconception educational materials identified	- MCH, MCH Epidemiologist, WIC
<b>Activity 1c.3:</b> Investigate sources of care for pregnant women who are uninsured or underinsured, including providers that offer payment options	-Resource guide/list of providers who offer services to pregnant women who are either uninsured or underinsured with information on payment options developed	-MCH, CHCC, State Medicaid Office
<b>Activity 1c.4:</b> Use social media to promote early and adequate prenatal care campaign.	-Number of pregnant women that receive early and adequate prenatal care	-MCH
<b>Activity 1c.5:</b> Provide	-Number of prenatal	- MCH, CHCC Women’s

prenatal care in the villages through the use of mobile clinic	care services provided through the mobile clinic	Clinic/ OB/GYN
<b>Activity 1c.6:</b> Increase awareness of Medicaid coverage availability for qualifying pregnant women	- Number of media campaigns relating to Medicaid	• MCH
<b>Activity 1c.7:</b> Develop MOU between Medicaid and MCHB to process presumptive eligibility for all pregnant women served by MCHB and Women's Clinic	-MOU between Medicaid Office and DPHS signed	• SSDI, MCH
<b>Goal 2: Promote the importance of breastfeeding</b>		
<b>Objectives: By 2017, increase number of women reporting breastfeeding, until at least six months of age, by 5%</b>		
<b>Activity 1d.1:</b> Maintain partnership with CHCC L&D unit to increase referrals to WIC breastfeeding Peer Counselor Program	-Number of patients referred to the WIC BF Peer Counselor Program by the CHCC L&D Unit	MCH, CHCC Women's • Clinic, CHCC L&D, WIC
<b>Activity 1d.2:</b> Implement data collection to capture breastfeeding mothers prior to discharge.	- Number of breastfeeding mom register in database/EHR	-SSDI, MCH
<b>Activity 1d.3:</b> Research and adopt evidence-based breastfeeding measures	-Evidence-based strategies identified	-MCH, MCH Epidemiologist
<b>Activity 1d.4:</b> Coordinate breastfeeding/lactation training for L&D/OB nurses so that they are able to provide breastfeeding support at delivery	-Number of health professionals at CHCC that receive annual training on breastfeeding and lactation	-MCH, CHCC Women's Clinic/ Children's Clinic/ L&D
<b>Activity 1d.5:</b> Develop a written policy that describes the practices to be used to promote inclusive breastfeeding, at least until months of age.	-Policy written, implemented at CHCC and distributed to all key stakeholders	-MCH, CHCC

<b>Activity 1d.6:</b> Increase awareness on the importance of breastfeeding	-Number of media campaigns relating to the importance of breastfeeding	-MCH, MCH Epidemiologist
<b>Goal 3: Promote the importance of practicing infant safe sleep habits</b>		
<b>Objectives: By 2017, established baseline for the number of families reporting practicing infant safe sleep habits</b>		
<b>Activity 1e.1:</b> Research safe sleep practices recommended by AAP	-AAP approved Safe Sleep practices identified	-MCH, MCH Epidemiologist
<b>Activity 1e.2:</b> Identify culturally appropriate evidence-based strategies, per the Asian/Pacific communities, to be used/referenced in developing written policy describing the practices used to promote safe sleep	-Evidenced-based strategies identified	-MCH, MCH Epidemiologist
<b>Activity 1e.3:</b> Identify data system to measure infant safe sleep reporting.	-Data system identified.	-SSDI, MCH, MCH Epidemiologist
<b>Activity 1e.4:</b> Review standard of care policies for all infants screened at CHCC to include safe sleep habits.	-Number of policies reviewed and amended	-MCH, CHCC
<b>Activity 1e.5:</b> Track all families with infants reporting safe sleep practices at CHCC Children's Clinic, WIC, and those enrolled in H.O.M.E Visiting Program.	<ul style="list-style-type: none"> <li>Number of families reporting practicing infant safe sleep habits</li> </ul>	-SSDI, MCH, CHCC Children's Clinic, WIC, H.O.M.E Visiting Program
<b>Activity 1e.6:</b> Use mass and small media to promote infant safe sleep habits.	<ul style="list-style-type: none"> <li>Number of media campaigns relating to safe sleep practices</li> </ul>	-MCH

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**NPM-4 A) Percent of infants who are ever breastfed**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	48.0	51.0	54.0	57.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	43.0	45.0	47.0	50.0

**NPM 5 - Percent of infants placed to sleep on their backs**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45	50	55	60	65

The 2014 accomplishments included the expansion of breastfeeding training for providers by Women, Infants, and Children (WIC) ; realignment of MCH programs; the use of quality improvement methods to improve early hearing detection and intervention; formation of the CNMI Fetal Infant Mortality Review team and participation in the regional CoIIN for to reduce infant mortality and improve birth outcomes; promotion of policies to eliminate unnecessary deliveries before 39 weeks; and coordination among initiatives promoting developmental screening. Challenges included identifying strategies to address the social determinants of health and the lack of a data system to capture developmental screening information. Although the CNMI's performance has been effected by the suspension of the Newborn Screening Program, management and leadership of CHCC have committed and are working closely with the MCH Program to reinstate services immediately.

**NPM 1 – The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.**

Annual Objectives and Performance Data

NPM#1	2010	2011	2012	2013	2014
Performance Data	100.0	100.0	N/A	N/A	100.0

	2016	2017	2018	2019	2020
Annual Objective	100.0	100.0	100.0	100.0	100.0

**Interpretation of Performance Data (Form 10D):**

Newborn screening has just been reinstated in a limited capacity but given the small number of positives (usually <10) the percent who receive timely follow up should be 100%.

**Summary of Activities related to Performance Measure:**

Since the inception of the Commonwealth Healthcare Corporation, a quasi-governmental health agency, newborn screening services were suspended due to lack of funding. However, the program has been working closely with the Chief Medical Laboratory Officer on addressing issues hindering the resumption of this critical service. The MCH Program has also partnered with a recently opened local diagnostic laboratory vendor who provides newborn blood spot screenings for data sharing, referrals, and followups on abnormal tests. The Pacific Medical Lab provides data on the number of newborns tested after discharge and the number of abnormal results. A data sharing MOU with the private lab has been initiated and will be finalized by next year.

**NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.**

NPM#11	2010	2011	2012	2013	2014
Performance Data	25.1	51.6	26.0	30.1	47.2

	2016	2017	2018	2019	2020
Annual Objective	40.0	43.0	45.0	47.0	50.0

**Interpretation of Performance Data (Form 10D):**

Increased number of mothers breastfeeding at 6 months.

**Summary of Activities related to Performance Measure:**

The CNMI MCH Program continues to design program efforts towards increasing breastfeeding initiation immediately after birth and up to six months of age. The program collaborates closely with WIC to ensure those served by both programs have the support and guidance needed for mothers to initiate and continue breastfeeding. In addition, training providers has been another milestone of the CHCC. Access to breastfeeding information and free-rental breast pumps are also available for families enrolled under WIC. Furthermore, considering a request by nurses to be properly trained on breastfeeding lactation and initiation, MCH resources will be utilized for three Labor & Delivery (L&D) nurses to attend a lactation conference and training at the end of 2015. The partnership between the MCH Program and WIC played an integral part in the increased rates of breastfed babies.

The WIC Program contracted a Lactation Consultant (IBCLC) to provide technical assistance with policies and procedures, feedback of breastfeeding program and Peer Counseling program, remote consults (via online video chat or telephone), and training (development and on-site training at the CHCC Hospital and WIC Clinic). The

Lactation Consultant did an on-site two (2) day training and mentoring with the Labor and Delivery, Neonatal Intensive Care Unit (NICU), and Maternity nurses, included an hour training with the Obstetricians/Gynecologists and Pediatricians. As well as an on-site training three (3) days training and mentoring with the CNMI WIC Clinic staff. The Peer Counseling Program sponsored by WIC continues to be another major success for the CNMI. Peer Counselors continue to help support and promote breastfeeding women in the community by providing services to pregnant and postpartum women in the WIC clinic. A MOU between the program and the hospital (Labor and Delivery, and Maternity Department) for hospital visits was also finalized.

**NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.**

NPM#12	2010	2011	2012	2013	2014
Performance Data	97.9	98.1	97.4	98.0	97.3

	2016	2017	2018	2019	2020
Annual Objective	99.0	99.0	99.0	100.0	100.0

**Interpretation of Performance Data (Form 10D):**

Newborn hearing screening continues to be close to 99%.

**Summary of Activities related to Performance Measure:**

The EHDI Program for the past five years has screened over 97% of babies born in the CNMI prior to hospital discharge. MCH Program will continue to work closely with the program to ensure continued success, such as with its ongoing quality assurance and improvement study which sets out to “Reduce nursery refer rate to 6% or less.” By reducing the Refer Rate from nursery, the EHDI Program limits the risk of having babies who are loss to follow-up.

Activities that have help lead up to screening over 97% of babies born in the CNMI, include:

- Audiologist diagnoses babies for hearing loss at less than 1 month of age and are referred to EI for services.
- EHDI Program continually coordinates the Deaf and Hard of Hearing (DHH) Family Event.
- EHDI Program coordinated with the Hawaii Deaf-Blind Project to create a resource book for DHH families.
- EHDI Program provided FREE American Sign Language (ASL) classes for parents for the DHH children.
- Early Intervention Services Program continually does child-find activities at Saipan, Tinian and Rota.
- EHDI Program has a Hearing Aid Loaner Program from those families that cannot afford or are not enrolled in EI yet.

**Child Health**

**Child Health - Plan for the Application Year**

**Domain: Children's Health**

**Plans for Application Year**

**Priority: Improve child health through providing vaccinations and screening for developmental delays**

Goals/Objectives/Activities	Data/Evaluation	Program Staff Responsible
<b>Goal 1: Promote public education and awareness on the importance of immunizations</b>		
<b>Objectives: By 2017, increase number of children receiving vaccination coverage by 2%</b>		
<b>Activity 1f.1:</b> Develop an MOU with private and public schools, including daycare centers, to provide vaccination on-sites.	-MOU developed	MCH, CHCC Immunization Program, CNMI Public School System, participating Private Schools, Participating daycare centers
<b>Activity 1f.2:</b> Utilize mobile clinic to conduct vaccination throughout identified villages	-Number of vaccinations provided to children	-MCH, CHCC immunization Program
<b>Activity 1f.3:</b> Develop database to include vaccination rates stratified by location, event, etc.	-Database developed	-SSDI, MCH
<b>Activity 1f.4:</b> Use mass and small media to promote vaccinations	-Number of media campaigns relating to the importance of vaccinations	-MCH
<b>Activity 1f.5:</b> Identify effective evidence-based activities promoting immunization coverage for children	-Evidence-based strategies identified	-MCH, CHCC Immunization Program
<b>Goal 2: Increase the proportion of young children screened for developmental delays</b>		
<b>Objectives: By 2017, established baseline for the number of children screened for developmental delays by5%</b>		
<b>Activity 1g.1:</b> Implement the Ages and stages Questionnaire (ASQ:3) screening tool at CHCC Children's Clinics	Questionnaire screening tool administered	ECCS Program, CHCC
<b>Activity 1g.2:</b> Purchase	-ASQ:3 purchased and	-MCH

ASQ:3 screening tool for all sites who currently does not have one	onsite	
<b>Activity 1g.3:</b> Work with CHCC IT department to implement ASQ:3 patient results into the HER “Well Child Schedule”	-EGR Well Child Module implemented and accessible	SSDI, MCH, CHCC IT Department
<b>Activity 1g.4:</b> Train all CHCC clinic staff, including those at the satellite clinics, who will be administering the ASQ:3	-Number of staff trained	-MCH
<b>Activity 1g.5:</b> Develop and implement ASQ:3 standard operating procedure for all clinics administering the ASQ:3	-Standard operating procedure finalized	-MCH, CHCC
<b>Goal 1: Promote public education and awareness on healthy adolescent behaviors, including risky behavior</b>		
<b>Objectives: By 2017, established baseline for the number of adolescents who report being bullied by 5%</b>		
<b>Activity 1h.1:</b> Develop MOUs with the schools for the intention of reducing bullying through an anti-bullying campaign partnership	-MOUs developed and signed between all schools and DPHS signed	-MCH, CNMI Public School System, participating Private Schools
<b>Goals/Objectives/Activities</b>	<b>Data/Evaluation</b>	<b>Program Staff Responsible</b>
<b>Activity 1h.2:</b> Identify culturally appropriate evidence-base “anti-bullying” curriculum/model to utilize in the schools	-Curriculum/model identified	-MCH, CNMI Public School System, participating Private Schools
<b>Activity 1h.3:</b> Conduct “town-	-Number of meetings	-MCH, MCH Epidemiologist

hall” type sessions for parents at school PTSA meetings regarding bullying and other risky behaviors, including MCH campaign to reduce such behaviors.	conducted for parents/community at school PTSAs	
<b>Activity 1h.4:</b> Use mass and small media to promote awareness on anti-risky behaviors, including anti-bullying.	-Number of media campaigns relating to anti-risky adolescent behaviors	-MCH
<b>Activity 1h.5:</b> Modify Title V database to include data fields relating to bullying.	-Database modified	-SSDI, MCH
<b>Activity 1h.5:</b> Develop bullying and bullying prevention survey for school students in order to establish baseline.	-Survey created and disseminated	-MCH, MCH Epidemiologist, SSDI
<b>Goal 2: Promote public education and awareness on poor adolescent health outcomes, including teenage pregnancies.</b>		
<b>Objectives: By 2017, decrease the rate of teenage pregnancies by 5%.</b>		
<b>Goals/Objectives/Activities</b>	<b>Data/Evaluation</b>	<b>Program Staff Responsible</b>
<b>Activity 1i.1:</b> Develop MOUs with the schools for the implementation of a public health course and student services through the mobile clinic.	-MOUs developed and signed between all schools and DPHS signed	- MCH, CNMI Public School System, participating Private Schools
<b>Activity 1i.2:</b> Identify culturally appropriate evidence-based curriculum/ model to utilize in the schools aimed at reducing poor adolescent health outcomes.	-Curriculum/model identified	-MCH, CNMI Public School System, participating Private Schools
<b>Activity 1i.3:</b> Identify funding for mobile clinic use and activities	-Mobile clinic in use at school sites with student services provided, such as with counseling, screenings, etc.	-MCH

<b>Activity 1i.4:</b> Use mass and small media to promote awareness on poor adolescent health outcomes, including teen pregnancies.	-Number of media campaigns relating to poor adolescent health outcomes	-MCH
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**Child Health - Annual Report**

**NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	60	64	68	72	76

Community and school based activities continued for the program in 2014 to assist with program’s efforts to reduce health disparities. Immunization were provided at Children’s Developmental Assistance Center and at Head Start centers. Fluoride varnish and sealant application were also conducted at Head Start centers, WIC and Immunization clinics. School partners were provided with information and offered opportunities for MCH staff to conduct presentations on preventative screenings and services to the students. Social media was another tool used by the MCHB to reach the community. In 2014, the MCH programs posted health tips, reports, and other information to over 400 “friends” on Facebook and Twitter.

**NPM 7 – Percent of 19 to 35 months old who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.**

NPM#7	2010	2011	2012	2013	2014
Performance Data	77.0	87.2	76.6	55.3	73.5

	2016	2017	2018	2019	2020
Annual Objective	82.0	83.0	84.0	85.0	86.0

**Interpretation of Performance Data (Form 10D):**

Inability to use electronic methods to monitor data resulted in decreased rates in 2013. Implementation of EHR in 2014 improved reliability of data. The EHR will continue to be used for data extraction in the future.

**Summary of Activities related to Performance Measure:**

MCHB stresses the importance of vaccinations throughout its programs and assists many of the families enrolled in the CNMI-MIECHV H.O.M.E. Visiting Program in accessing the Immunization Program through either gas vouchers for their personally owned vehicles or ride vouchers for use of the “Call-a-ride” Program, under the government’s

Commonwealth Office of Transit Authority.

Programs under MCHB, such as CSHCN Program, EHDI Program, EIS Program, and the H.O.M.E. Visiting Program, continuously track enrolled clients to ensure they are up-to-date with their vaccinations and coordinate arrangements for families to receive such vaccinations if need be.

Future activities include assisting the Immunization Program in reaching out to all children and individuals in need of up-to-date vaccinations and continuing to spread awareness on the importance of vaccinations through different media outlets, such as with radio ads, magazine/newspaper ads and local TV advertisements.

**NPM 10 – The rate of death to children aged 14 years and younger caused by motor vehicle crashes per 100,000**

NPM#10	2010	2011	2012	2013	2014
Performance Data	0.0	0.0	0.0	0.0	0.0

	2016	2017	2018	2019	2020
Annual Objective	0.0	0.0	0.0	0.0	0.0

**Interpretation of Performance Data (Form 10D):**

No deaths associated with motor vehicle accidents.

**Summary of Activities related to Performance Measure:**

Over the past year, MCHB has undergone training with the local Department of Public Safety on proper infant and child safety seat installation and CNMI child passenger safety laws. All programs under MCHB stress the importance of proper use, including the use, of infant and child safety seats. The H.O.M.E. Visiting Program recently purchased six (6) Infant/Child Convertible Car Seats to be used as loaners for needing families ready to be discharged from Labor & Delivery, as well as to be used by the Commonwealth Office of Transit Authority (COTA) who serves as the only true public transit system in the CNMI.

**Future activities include applying for the “Child Safety CollN with the goal of reducing 100,000 fatalities and hospitalizations from preventable injuries among infants, children, and adolescents over the next three years.”**

**Adolescent Health**

**Adolescent Health - Plan for the Application Year**

**Domain: Adolescent Health**

**Plans for Application Year**

**Adolescent Health - Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide)**

<b>Goal 1: Promote public education and awareness on healthy adolescent behaviors, including risky behavior</b>		
<b>Objectives: By 2017, established baseline for the number of adolescents who report being bullied by 5%</b>		
<b>Activity 1h.1:</b> Develop MOUs with the schools for the intention of reducing bullying through an anti-bullying campaign partnership	-MOUs developed and signed between all schools and DPHS signed	-MCH, CNMI Public School System, participating Private Schools
<b>Goals/Objectives/Activities</b>	<b>Data/Evaluation</b>	<b>Program Staff Responsible</b>
<b>Activity 1h.2:</b> Identify culturally appropriate evidence-base “anti-bullying” curriculum/model to utilize in the schools	-Curriculum/model identified	-MCH, CNMI Public School System, participating Private Schools
<b>Activity 1h.3:</b> Conduct “town-hall” type sessions for parents at school PTSA meetings regarding bullying and other risky behaviors, including MCH campaign to reduce such behaviors.	-Number of meetings conducted for parents/community at school PTSAs	-MCH, MCH Epidemiologist
<b>Activity 1h.4:</b> Use mass and small media to promote awareness on anti-risky behaviors, including anti-bullying.	-Number of media campaigns relating to anti-risky adolescent behaviors	-MCH
<b>Activity 1h.5:</b> Modify Title V database to include data	-Database modified	-SSDI, MCH

fields relating to bullying.		
<b>Activity 1h.5:</b> Develop bullying and bullying prevention survey for school students in order to establish baseline.	-Survey created and disseminated	-MCH, MCH Epidemiologist, SSDI
<b>Goal 2: Promote public education and awareness on poor adolescent health outcomes, including teenage pregnancies.</b>		
<b>Objectives: By 2017, decrease the rate of teenage pregnancies by 5%.</b>		
<b>Goals/Objectives/Activities</b>	<b>Data/Evaluation</b>	<b>Program Staff Responsible</b>
<b>Activity 1i.1:</b> Develop MOUs with the schools for the implementation of a public health course and student services through the mobile clinic.	-MOUs developed and signed between all schools and DPHS signed	- MCH, CNMI Public School System, participating Private Schools
<b>Activity 1i.2:</b> Identify culturally appropriate evidence-based curriculum/ model to utilize in the schools aimed at reducing poor adolescent health outcomes.	-Curriculum/model identified	-MCH, CNMI Public School System, participating Private Schools
<b>Activity 1i.3:</b> Identify funding for mobile clinic use and activities	-Mobile clinic in use at school sites with student services provided, such as with counseling, screenings, etc.	-MCH
<b>Activity 1i.4:</b> Use mass and small media to promote awareness on poor adolescent health outcomes, including teen pregnancies.	-Number of media campaigns relating to poor adolescent health outcomes	-MCH

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75	70	65	60	55

**Adolescent Health Domain**

The CNMI MCH Program, together with all programs targeting the MCH population, will identify evidence-based strategies to educate adolescents on both abstinence and contraception, promoting health behaviors, and reducing poor outcomes. The program in collaboration with key stakeholders will create an integrated system of care and linkages to support services to address the priorities for adolescent health. Continued efforts to address teen pregnancy and other risky behaviors will be in collaboration with the CNMI MCH Title X Program.

**NPM 8 – The rate of birth (per 1,000) for teenagers aged 15 through 17 years.**

NPM#8	2010	2011	2012	2013	2014
Performance Data	37.5	27.1	16.3	27.7	24.1

	2016	2017	2018	2019	2020
Annual Objective	15.5	15.0	14.5	14.0	13.0

**Interpretation of Performance Data (Form 10D):**

Rates decreasing gradually and renewed access to LARCs, following Project Choice model, should help continue the decline.

**Summary of Activities related to Performance Measure:**

MCH Program has worked hard over the past year to increase awareness surrounding teen pregnancies. One of MCHB’s key campaign surrounding teen pregnancy was the filming of three TV commercials aimed at highlighting the statistics and consequences of teen pregnancies. Commercials were aired on the local TV channel, as well as at the only movie theater on island. In collaboration with the CNMI Public School System, local high school students were used for both acting and voice-overs. With one of MCHB’s new selected priority being to “Improve adolescent health by promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use, bullying) and poor outcomes (i.e. teen pregnancy, injury, suicide),” MCHB, in terms of teen pregnancy rates, intends to establish the use of CHCC’s Mobile Clinic at various high school sites for students to access education, services and support surrounding adolescent/teenage health, such as with teenage pregnancy.

Future activities include working closely with Teen Talk and both the Public and Private schools in identifying an evidence-based curriculum designed to help reduce teenage pregnancies and promote healthy behaviors and peer support.

**Children with Special Health Care Needs**

**Children with Special Health Care Needs - Plan for the Application Year**

**Domain: Children with Special Health Care Needs.**

**Plans for Application Year**

**Priority: Provide a medical home for children identified as Children with Special Health Care Needs.  
Improve identification of CSHCN through screening for developmental delays.**

Goals/Objectives/Activities	Data/Evaluation	Program Staff Responsible
<b>Goal 1: Increase the proportion of CSHCN having an established medical home.</b>		
<b>Objectives: By 2017, established baseline for the number of CSHCN who report having an established medical home by 2%.</b>		
Goals/Objectives/Activities	Data/Evaluation	Program Staff Responsible
<b>Activity 1j.1:</b> Maintain partnership with the CHCC and Private Clinics, with a focus on enrolling identified CSHCN.	- Number of CSHCN who receive preventive and treatment health services within a medical home	-MCH, CHCC, Private Clinics
<b>Activity 1j.2:</b> Advocate for Medicaid and Private Insurance coverage for patients not otherwise eligible for such coverages.	- Number of identified CSHCN with adequate private and/or public insurance coverage each year	-MCH, State Medicaid Office
<b>Activity 1j.3:</b> Use mass and small media to promote the provision of medical homes for CSHCN, provide appointment reminders, etc.	- Number of identified CSHCN that are linked to a medical home and have schedule follow up appointments with an identified primary care provider	-MCH, CSHCN Program
<b>Activity 1j.4:</b> Develop educational materials designed to increase public awareness on the importance of establishing a medical home for CSHCN.	-Number of educational materials developed	-SSDI, MCH

<b>Activity 1j.6:</b> Develop a state-wide CSHCN comprehensive care plan.	-Comprehensive care plan developed	-MCH, MCH Epidemiologist, CSHCN Program
<b>Goal 2: Improve identification of Children with Special Health Care Needs through screening for developmental delays.</b>		
<b>Objectives: By 2017, established baseline for the number of CSHCN identified through developmental delay screenings by 5%.</b>		
<b>Activity 1k.1:</b> Meet with ECCS partners to identify roles, responsibilities, and strategies towards a coordinated approach in integrating program services to ensure screenings, referrals, evaluations, and connecting those in need to services they are eligible for.	- MOU developed detailing roles, responsibilities, and strategies of all partners involved	- MCH, ECCS Program, key stakeholders

**Children with Special Health Care Needs - Annual Report**

**NPM 11 - Percent of children with and without special health care needs having a medical home**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45	50	55	60	65

Other strategies to meet the CNMI MCHB’s vision of healthy mothers, children, including children with special healthcare needs, and families in the CNMI included recruiting critical positions to improve and address the gaps in the program’s workforce capacity including a MCH Epidemiology to improve data capacity and inform decision making at all levels, MCH Services Coordinator to assist with care coordination and eligibility services, Outreach Worker to reach a broader audience, and a Fiscal Specialist to manage overall accounting responsibilities of the programs within the Bureau. A major accomplishment in 2014 was the restructuring of one of the Early Intervention Services Coordinators to addresses the gaps in care coordination of children with special health care needs not served by the Shriner’s or Early Intervention Services. Ann Marie Satur was recruited in 2014 as the Children with Special Healthcare Needs Coordinator, charged with addressing the priority to identify, track, and direct activities

related to improving services to this vulnerable population.

**NPM 2 – The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive (CSHCN survey)**

NPM#2	2010	2011	2012	2013	2014
Performance Data	59.0	59.0	59.0	78.0	78.0

	2016	2017	2018	2019	2020
Annual Objective	75.0	75.0	77.0	77.0	79.0

**Interpretation of Performance Data (Form 10D):**

In general, the CSHCN survey is only done every other year, hence the annual objective will be the same for 2 years in a row. The large increase in 2013 may be due to the increased number of surveys obtained, particularly from Rota and Tinian.

**Summary of Activities related to Performance Measure:**

The recruitment of a Children with Special Healthcare Needs Coordinator in line with the program’s goals to ensure activities are family-centered approach providing care coordination and other required support for families. The program continued to work with national and local partners to ensure MCH groups were considered in their efforts. For instance, the program’s partnership with Shriner Children’s Hospital in Honolulu includes outreach services to provide specialty care for CSHCN in the CNMI. The program also partnered with the Chief Pediatrician of the CHCC Children’s Clinic to host the first ever CNMI Bleeding Disorder Conference. The first ever CNMI Bleeding Disorder Conference and Family Camp saw a very successful turnout. The conference, which covered disorders such as hemophilia and von Willebrand's disease, was held from December 14th-21st for medical providers, nurses, dentists, therapists, school trainers, coaches, and families. Led by the CHCC’s Dr. Tiffany Lin and Pam Carhill, MPT, of Marianas Health, the overall goal of the conference was to raise awareness in the CNMI and educate providers and affected families about these uncommon diseases. The event was sponsored by the DPHS, MCH, Biogen Idec., Los Angeles Orthopedic Institute for Children, and Marianas Health. The Northern Mariana Islands Football Association (NMIFA) and Western States Hemophilia Network also provided volunteers and technical assistance.

The conference comprised of three (3) different learning sessions for providers and two (2) days for the families affected by a bleeding disorder. On Sunday, December 14, 2014, more than 50 coaches, PE teachers, and trainers attended the Hemophilia and von Willebrand’s Disease 101 session. According to a post conference evaluation, almost 90% of the coaches and PE teachers learned something new and approximately 70% found the materials used in the sports preparation lecture useful. Dental hygienists, Social Workers, Social Worker Assistants, Certified Nurses Assistants, NMC nursing students, and Physical Therapists participated in another event the following day. The providers also had the opportunity to meet Saipan’s Bleeding Disorder Team and learn more about their goals and how they can collaborate to serve this unique population. The last session for Physicians, Physician’s Assistants, Nurse Practitioners, Midwives, Dentists, and Pharmacists received the best review with 100% of attendees noting that they enjoyed attending the conference. Immediately following the conference, families of children with bleeding disorders attended a two day retreat with the providers. The program plans to collaborate with

the Bleeding Disorder Team in 2015.

Other ongoing activities and strategies to address perinatal and infant health included the annual Shriner’s Outreach Clinic providing orthotics restoration services for CSHCN at no cost to CNMI families. Referrals continued in 2014 for patients requiring specialized care off-island. EHDI Program staff also developed a resource book for Deaf and Hard of Hearing (DHH) patients and sponsored the development of a resource book for DHH families. They also coordinated with CHCC, ENT’s two weeks visit for CSHCN.

**NPM 3 – The percent of children with special health care needs age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSPHCN survey)**

NPM#3	2010	2011	2012	2013	2014
Performance Data	26.9	26.9	26.9	46.1	46.1

\*Please note that the data reflective is based on the CSHCN 2013 Survey. Due to recent change is SSDI Project Officer and the use of wrong CSHCN survey, the CNMI was unable to collect 2014 data per this measure.

	2016	2017	2018	2019	2020
Annual Objective	40.0	40.0	42.0	42.0	44.0

**Interpretation of Performance Data (Form 10D):**

In general, the CSHCN survey is only done every other year, hence the annual objective will be the same for 2 years in a row. The large increase in 2013 may be due to the increased number of surveys obtained, particularly from Rota and Tinian. [Also, there is no definition of “medical home” so there is uncertainty about whether the respondents truly understand what the question is.]

**Summary of Activities related to Performance Measure:**

MCH Program collaborates with the CSHCN Program to continuously ensure that children and families identified with a special health care need are linked to all applicable services and providers. In the event that a CSHCN may require more than one specialist and/or provider, the CSHCN Program works closely with the families and specialists/providers to ensure smooth transition between all entities involved. The CSHCN Program goal is to identify and track all CSHCN and provide care coordination within a functioning medical home.

Additionally, the Early Childhood Comprehensive Services (ECCS) Program, under MCHB, has implemented the use of the ASQ-3 at CHCC’s Children’s Clinic and participating certified Day Care Centers. The ECCS Program has started collecting such data from implementing sites.

**NPM 4 – The percent of children with special health care needs age 0-18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN survey)**

NPM#4	2010	2011	2012	2013	2014
Performance Data	59.0	59.0	59.0	56.5	56.5

	2016	2017	2018	2019	2020
Annual Objective	60.0	60.0	61.0	61.0	62.0

**Interpretation of Performance Data (Form 10D):**

Data from 2014 is not available but between 2010 and 2013, even with an increased respondents, almost half of families do not have adequate insurance to cover needed services.

**Summary of Activities related to Performance Measure:**

Currently, part of the CSHCN Program’s service coordination is to assist families apply for or renew their current medical insurance to help pay for services not covered by the program. Additionally, the hiring of an MCH Services Coordinator has allowed program to update its MOU with the State Medicaid Office to include, amongst other data sharing services, the allowance to receive, review, and submit MCH client’s Medicaid application for processing, and furthermore, to expedite the processing of MCH client’s Medicaid application.

All programs under MCHB assist in referring families to the Medicaid Office, CHCC’s “Sliding Fee Scale” program, as well as to the Commonwealth Office of Transit Authority (COTA) to help families apply or renew coverages.

Future activities include continue to assist with Medicaid applications and referrals and link all CSHCN to a medical home.

**NPM – 5 Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN survey)**

NPM#5	2010	2011	2012	2013	2014
Performance Data	52.2	52.2	52.2	69.8	69.8

	2016	2017	2018	2019	2020
Annual Objective	65.0	65.0	67.0	67.0	69.0

**Interpretation of Performance Data (Form 10D):**

As of 2013, the majority of CSHCN families feel that community services are organized for ease of use. 2014 data is not available.

**Summary of Activities related to Performance Measure:**

Through the CSHCN Program/EIS Program updating its current data system and establishment of SOPs, referral and intake forms, and MOUs with partner agencies, CSHCN receiving care in a well-functioning system can be effectively tracked and measured. MCHB sets to stablish CSHCN “Teams” that cater to specific groups so that, for

instance, the Orthopedic Team will support families that have children with an orthopedic impairment and the Global Team will support families with children who have global health care needs. These teams are envisioned to link families to other services, be a part of their health care planning, education planning, and transition planning. The EIS Program links families to different appropriate community-based services systems. The MCH Program will continue to work closely with the EIS Program to further improve service systems access.

Future activities include ensuring that all programs under MCHB are aware and updated on the different services provided by other programs/partner agencies in order to ensure the coordination of services, conduct corrected version of the CSHCN Survey in conjunction with PSS-SPED, and continue to work with the Commonwealth Office of Transit Authority on collaboration of services for families.

**NPM 6 – The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.**

NPM#6	2010	2011	2012	2013	2014
Performance Data	6.7	6.7	6.7	9.9	9.9

	2016	2017	2018	2019	2020
Annual Objective	9.0	9.0	10.0	10.0	11.0

**Interpretation of Performance Data (Form 10D):**

Although the indicator exceeds the objective, still only 10% of YSHCN receive the needed transition services. This is obviously an area where more work is needed.

**Summary of Activities related to Performance Measure:**

A Memorandum of Agreement will continue to be updated to establish data sharing between the Public School System Special Education Program and the CHCC. CSHCN “teams” will be established as well to ensure a comprehensive transition occurs into all aspects of adult life. Some examples of CSHCN Teams may include: Deaf and Hard of Hearing, Orthopedics, Mental/Behavioral, Hemophilia, Cardiac, Respiratory, Developmental Disabilities, Cleft Lip/Palate, ENT, Dermatology, Vision, Global, Transition, and Advocacy teams. Each team will consist of parents, professionals, pediatricians, teachers, and members of agencies that may have a direct impact on any specific disorder.

Future activities include continuing to work with partnering agencies and families to discuss the transition of health care from pediatric to adult provider.

**Cross-Cutting/Life Course**

**Cross-Cutting/Life Course - Plan for the Application Year**

**Domain: Cross-Cutting/Life Course**

**Plans for the Application Year**

**Priority: Improve oral health of children and pregnant mothers.**

**Improve insurance status of children and pregnant mothers.**

Goals/Objectives/Activities	Data/Evaluation	Program Staff Responsible
<b>Goal 1: Improve the health of children by promoting oral health</b>		
<b>Objectives: By 2017, increase number of children and pregnant mothers receiving oral health care services by 2%</b>		
<b>Activity 11.1:</b> Identify culturally appropriate evidence-based oral health care education to be incorporated in the WIC Group Prenatal Care curriculum.	-Oral health care education model identified	-MCH, Oral Health Program, WIC
<b>Activity 11.2:</b> Maintain partnership with all public and private clinics to include as a part of prenatal visits, oral health assessments and education and health promotion counseling for oral health during pregnancy.	-Number of visits with oral health education and promotion counseling included	-MCH, CHCC, Private Clinics
<b>Activity 11.3:</b> Use mass and small media to promote oral health care for children and pregnant women, provide appointment reminders, etc.	-Number of prenatal patients that had an oral health screen completed	-MCH
<b>Activity 11.4:</b> Maintain and/or establish partnerships with public and private dental clinics to increase access to dental care.	-Number of partnering dental providers	-SSDI, MCH

<b>Goal 2: Improve insurance status of children and pregnant women</b>		
<b>Objectives; By 2017, increase number of children and pregnant mothers who report having adequate insurance coverage by 2%</b>		
<b>Activity 1m.1:</b> Maintain partnership with CHCC's L&D unit to ensure that all Medicaid insured or uninsured women seen at L&D are provided with information on accessing Medicaid coverage by providing application forms and guide.	-Number of patients at the CHCC L&D unit that receive information on accessing Medicaid coverage	- MCH, CHCC
<b>Activity 1m.2:</b> Provide guidance to partnering agencies on Medicaid eligibility and requirements.	-Number of partnering agency staff provided information on Medicaid eligibility and requirements	-MCH
<b>Activity 1m.3:</b> Identify MCHB personnel to assist in processing application forms.	-Personnel identified	-MCH
<b>Activity 1m.4:</b> Identify referral tracking system.	-Referral tracking system identified and used	-MCH
<b>Activity 1k.2:</b> Implement the Ages and Stages Questionnaire (ASQ:3) screening tool at CHCC Children's Clinic, including satellite clinics.	- Ages and Stages Questionnaire screening tool administered	-MCH, CSHCN Program, ECCS Program, CHCC
<b>Activity 1k.3:</b> Purchase ASQ:3 screening tool for all sites who currently does not have one	-ASQ:3 purchased and onsite	-MCH
<b>Activity 1k.4:</b> Work with CHCC IT Department to implement ASQ:3 patient results into the EHR "Well Child Module."	- EHR Well Child Module implemented and accessible	-SSDI, MCH, CHCC IT Department
<b>Activity 1k.5:</b> Train all CHCC clinic staff, including those at the satellite clinics, who will be administering the ASQ:3.	-Staff trained	- MCH
<b>Activity 1k.6:</b> Develop and	-Standard operating	- MCH, CHCC

implement an ASQ:3 standard operating procedure for all clinics administering the ASQ:3.	procedure finalized	
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**Cross-Cutting/Life Course - Annual Report**

**NPM-13 A) Percent of women who had a dental visit during pregnancy**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	5.0	10.0	15.0	20.0	25.0

**NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.0	12.0	14.0	16.0	18.0

**NPM 15 - Percent of children ages 0 through 17 who are adequately insured**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50	55	60	65	70

**NPM 9 – Percent of third grade children who have received protective sealants on at least one permanent molar tooth.**

NPM#9	2010	2011	2012	2013	2014
Performance Data	87.6	90.0	65.0	N/A	15.2

\*Per this measure, the Oral Health Program only provides protective sealants to 2nd and 6th graders within the Public School System (PSS) when it resumed its School Sealant Program in November 2014. The Oral Health Program provided protective sealants to #121 PSS 2nd graders and #96 to PSS 6th graders. The denominator data is reflective of both the 2nd and 6th graders enrolled in PSS SY 2014.

	2016	2017	2018	2019	2020
Annual Objective	20.0	25.0	30.0	35.0	40.0

**Interpretation of Performance Data (Form 10D):**

Decrease in the percent of children receiving sealants after closure of dental clinic in 2012. Reopened in 2014 with sealant program but funding was lost in 2015 so future numbers may be lower until local funding is arranged.

**Summary of Activities related to Performance Measure:**

The Oral Health Program provides protective sealants to 2nd and 6th graders within the Public School System (PSS) when it resumed its School Sealant Program in November 2014. The Oral Health Program provided protective sealants to 121 second graders and 96 to sixth graders from PSS in 2014. The program will continue to work closely with Oral Health Program to ensure that oral health education, assessment, referrals, etc... are available and provided to children and pregnant women in the CNMI.

Future activities include continuing to broadcast the importance of maintaining good oral hygiene through different media outlets, continuing to coordinate referrals for PSS Head Start children in need of prophylaxis, and training and certifying all Family Advocates, under the H.O.M.E. Visiting Program, to be able to provide fluoride varnish applications every three months for the children and their siblings enrolled in the Program.

**NPM 13 - Percent of children without health insurance.**

NPM#13	2010	2011	2012	2013	2014
Performance Data	80.0	68.4	60.6	56.9	50.9

	2016	2017	2018	2019	2020
Annual Objective	49.0	48.0	47.0	46.0	45.0

**Interpretation of Performance Data (Form 10D):**

Even with the improvement in insurance rates for children since 2010, slightly more than half of the CNMI's children are without health insurance. Almost all of these children would qualify for Medicaid but are not enrolled and therefore may not receive the appropriate preventive services.

**Summary of Activities related to Performance Measure:**

Although the CNMI met the objectives on most of the national and state performance measures in 2014, low prenatal care rates, high dental caries among children, lack of available and quality data, lack of health coverage and services for families, and the lack of newborn screening services in the hospital are all challenges the program faced. The lack of providers with specialized skills continues to be a huge challenge for families with CSHCN. Many families struggle with high insurance premiums and most off island referrals only accept private insurance. In reviewing the expenditures and budget for the MCH Program, funds for direct health services are still the primary means of support the program provides to CHCC. This is a reflection of the decreased budget for the CHCC. Again, the program continues work with other programs that can provide direct health services while we focus on the other

three service levels of the MCH pyramid.

Future activities includes having the program work closely with both CHCC clinics and Private clinics to ensure all children are linked to a medical home, are ensured under Medicaid, should they qualify, and work with families throughout the CNMI on addressing the importance of having health care insurance and seeking regular medical care. The program will also work with the Medicaid Program to update existing State Plan which prohibits the expansion of CHIP coverage until local match has been expended.

**NPM 14 - Top of Form**

**Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.**

NPM#14	2010	2011	2012	2013	2014
Performance Data	22.6	23.3	29.9	20.8	30.0

	2016	2017	2018	2019	2020
Annual Objective	28.5	28.0	27.5	27.0	26.5

**Interpretation of Performance Data (Form 10D):**

Rates of overweight and obesity in children continue to rise with a large increase noted between 2013 and 2014.

**Summary of Activities related to Performance Measure:**

The CNMI WIC Program implemented the MIS system HANDS (Health and Nutrition Delivery System), which allows for case management of children enrolled in the program. The program will continue to work closely with WIC to ensure that all enrolled families under MCHB programs, who qualify for WIC, are indeed enrolled into the WIC Program and are receiving continuous health and nutrition counseling.

The MCH Program conducted outreaches to elementary and middle students to promote healthy living and physical activity. In collaboration with the Let’s Move Marianas Alliance, the program visited five (5) schools and also provided BMI assessments.

**NPM 15 - Percentage of women who smoke in the last three months of pregnancy**

NPM#15	2010	2011	2012	2013	2014
Performance Data	1.1	1.4	0.4	2.5	2.8

	2016	2017	2018	2019	2020
Annual Objective	0.0	0.0	0.0	0.0	0.0

### **Interpretation of Performance Data (Form 10D):**

The apparent increase in the percentage of women who smoke in the last three months of pregnancy may be related to better enumeration of tobacco use in pregnancy. Previous information was obtained from a random chart sample but more recently, information is being provided to the Health and Vital Statistics Office through birth certificate data and should be more accurate. Also, it is not clear if the tobacco question includes use with betelnut which is much higher usage but chewed, not smoked.

### **Summary of Activities related to Performance Measure:**

MCH Program has worked hard over the past year to increase awareness surrounding improving overall birth outcomes through its numerous educational campaigns on early and adequate prenatal care, preconception health, reproductive health, CNMI IM ColIN (infant mortality awareness) initiatives, as well as Medicaid prenatal eligibility for non U.S. citizens. Campaigns include: Developed TV commercials on the effects of teen pregnancy (3 different types), healthy cooking demonstrations using local grown produce, living a healthy lifestyle for Women and families, and preconception health, prenatal health and postnatal health; Outreach campaigns; Community forums; Weekly educational posts and activity updates on MCHB Facebook page. Additionally, this National Performance Measure is in line with the overall IM ColIN Learning Network Measure which tracks “the percentage of women who report smoking during pregnancy,” which the CNMI IM ColIN Team participates in.

### **Other Programmatic Activities**

To advance maternal and child health services in the CNMI, it is critical for the MCH Program to actively participate in other key partner/community activities. These include, for the reporting year, activities to address children’s health in collaboration with the Let’s Move Marianas Coalition, remaining actively involved with the CNMI’s ColIN Committee to meet the goals and objectives outlined in the “Blueprint for Change”, improving primary services at the only hospital located in Saipan and outlying clinics in Rota and Tinian, and providing resources to improve the data reporting capacity of partners serving the MCH population. Direct services for CSHCN and high risk pregnancies are also supported to ensure improved care coordination.

The MCH Program continues to support the reinstatement of the Newborn Screening Program at the only hospital in the CNMI. In the past, the program supported newborn screening by procuring test kits and postal fees to enable this critical service. The financial constraints of the CHCC have hindered the program’s efforts to reinstate Newborn Screening at the hospital. Thus, it is a critical mission for MCH to support all efforts that help bring back the program.

Although the CNMI’s participation to implement the ColIN initiative is new, the SSDI program throughout the years has been collecting and submitting infant mortality data for the MCH Title V Block Grant. The CNMI MCH Title V Data Repository is currently the data system used to store and track such data. The data repository will continue to be used to track the jurisdictions’ trend with infant mortality, as well as to support the meanings and implications of the infant mortality findings by the SSDI program and CNMI ColIN Strategy Team. Other data related activities include supporting training for providers and key MCH personnel on a population health software in the Electronic Health Record, called iCare. Additionally, the MCH Program Coordinator, MCH Title V Epidemiologist, and Consultant recently applied for a funding opportunity to improve coverage for adult Medicaid beneficiaries. Key maternal indicators will be tracked on iCare, therefore training workforce to utilize this new software is necessary.

While CHCC continues to struggle with the restructuring of the overall financial accounting of local and federal grants due to the separation from the central Department of Finance, MCHB recruited a Fiscal Specialist who will oversee and maintain the financial functions of assigned grants.

## II.F.2 MCH Workforce Development and Capacity

The CNMI MCH workforce is primarily housed within the Maternal and Child Health Bureau. The 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. 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 MCHB staff work within the Healthy Outcomes for Maternal and Early Childhood Visiting Program, carrying out the implementation of the CNMI HOME visiting work plan. The following are brief biographies of senior level management and key staff involved in the Title V needs assessment and application processes.

**Director of Public Health Services:** Margarita Torres-Aldan holds a Master's Degree in Public Health (Health Service Administration) from the University of Hawaii and a Bachelor of Science Degree from the University of Colorado, Denver. Aside from her experience in the MCH Program, she has experience in social work, including interagency liaisons, adolescent health, and services for CSHCN. Director Aldan continues to provide guidance and input to all programs within the MCH Bureau.

**Public Health Services Medical Director:** Daniel Lamar, MD, graduated from the National College of Naturopathic Medicine, Portland, OR as a Naturopathic Doctor in 1978 and the Oregon Health Sciences University Portland, OR as a Medical Doctor in 1990. He completed his family medicine residency at Poudre Valley Hospital in Ft. Collins, CO. Dr. Lamar has worked in the CNMI since 1993.

**Chair, Pediatric Inpatient Services:** Christopher Steadman, MD, graduated from the University of Utah, School of Medicine in 2008. He completed his general pediatrics residency at University of Minnesota in 2011. Dr. Steadman serves on the MCH Advisory Board and is also a member of the CNMI CoIIN Team. Dr. Steadman developed and maintains the CNMI's database to track infant mortality.

**CHCC Dental Clinic Dentist:** Dr. Adam Gentry was recruited in 2014 from Colorado. He has a DDS from the University Of Colorado School of Dental Medicine, and a BS in Financial Management from Grove City College, PA. As a FTE dentist for the Public Health Dental Clinic, he supervises the dental staff and provides preventive and curative dental work. As part of a partnership with the Women's and Children's Clinic, he collaborates with the OB/GYNs by providing assessment as well as oral health education to pregnant women at their clinic. He also assesses and provides services to CSHCN patients through referrals until the OR is able to resume services under general anesthesia for hard to manage patients.

The MCH Program supports the following full/part time positions:

**OB/GYN Physician/MCHB Epidemiologist:** Jeanolivia Grant, MD, graduated from Thomas Jefferson University Medical School and completed her residency at Temple University in the inner city of Philadelphia. She completed her master's degree in Public Health from the University of North Texas in Epidemiology. She is the Department Chair for the CHCC OB/GYN unit and provides clinical services as well as input and assistance to the preventive programs at the Division of Public Health Services. She maintains a .3 FTE as the MCHB Title V Epidemiologist.

**MCH Program Coordinator/MCH Bureau Administrator:** TaAnn Temeing Kabua recently assumed duties as the MCH Program Coordinator. She holds an AA degree in Liberal Arts from the Leeward Community College in Honolulu HI. She is currently pursuing a BS in Education with a concentration in Rehabilitation and Human Services

and is expected to graduate this year. Prior to becoming the MCH Program Coordinator, she managed the overall programmatic activities for the SSDI Grant for over two years. She completed numerous public health trainings and continues to serve on various committees. Since assuming duties as the MCH Program Coordinator, Ms. Kabua led the merge of all MCH programs into one Bureau, in turn eliminating duplication of efforts and improving efficiency of program efforts. Ms. Kabua also volunteers in community organizations. She is a member of Marianas Young Professionals, a non-profit organization representing a broad range of professionals across the CNMI.

**SSDI Project Coordinator/MCHB Data Analyst:** Shawnalei Ogumoro graduated from Eastern Oregon University with a BS in Anthropology/Sociology, with emphasis in Anthropology in 2008. Related coursework completed included: culture health and illness, information access, and statistics. Ms. Ogumoro was the former data manager for the MCH H.O.M.E Visiting Project. She currently serves as the SSDI Project Coordinator and Data Analyst. While SSDI does not directly provide services to mothers and children, the Program is responsible for obtaining and disseminating valuable data needed to support the existing programs under MCHB, partnering agencies, and the population it serves as whole, including CSHCN. To do such, SSDI conducts focus groups across the MCH population health domains, including adult women under the local penal system, to garner their individual/familial/community needs and unmet needs necessary for both understanding and improving access to services, based on their changing and varied needs. SSDI also takes part in all Title V activities, such as with the Needs Assessment, as an opportunity to work closely with families and key agencies to ensure that MCHB has the capacity to report on elements required under Title V. The compilation of such data, including the retrieval of pertinent data from partnering agencies, are maintained in the Title V database and is used to provide data support and capacity for MCH.

**ECCS Project Coordinator/MCHB Fiscal Specialist:** Maxine Pangelinan, graduated from Arizona State University, in Tempe, AZ with a BS in Psychology in 2005. She has served as the ECCS Project Coordinator since 2007. Ms. Pangelinan has been a part of the CJPA Youth Advisory Committee since 2008. She obtained her MBA with a concentration in Accounting in 2014 and is currently the MCHB Fiscal Specialist. Ms. Pangelinan remains the Acting ECCS Project Coordinator until a replacement is hired. The MCHB Fiscal Specialist will be supported by the Title V grant partially at .5 in the next budget year.

**MCH Services Coordinator:** Mr. Yarobwemal serves as the MCH Service Coordinator and Acting Family Planning Manager. He holds a BS 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. He was also a nursing assistant for eight years at CHCC before moving to PSS. Mr. Yarobwemal volunteer work for faith-based and community organizations such as the teaching at the Confraternity of Christian Doctrine classes has linked many families to the MCH Program. His respectable reputation in the community as well as his knowledge of health programs have been valuable assets for the program.

**Children with Special Health Care Needs Coordinator:** Ann Marie Satur administers all activities for CSHCN. She was born and raised in Saipan, CNMI. She graduated from Northern Marianas College Saipan, MP in 2007 and graduated from Northern Marianas Academy Saipan, MP also in 2007. Ms. Satur attended Old Dominion University Norfolk, VA from 2007-2009. Ann Marie has been working with CHCC since 2011 as an Early Intervention Services Coordinator. She has taken the role of CSHCN Coordinator to ensure the activities detailed in the new CNMI MCH State Action Plan and priorities for CSHCN are met. The CSHCN component incorporates clinical, educational, vocational and social services for children and their families who are served under this program. New case screening and identification, tracking and monitoring, service/care coordination and provision of ongoing comprehensive services outline the CSHCN projects scope. Ms. Satur will continue to work closely with staff of the Early Intervention Services Program in carrying out the overall CSHCN activities in accordance to the MCH grant.

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 MCH Bureau continue to meet major milestones and objectives. The following are key MCHB staff:

**H.O.M.E. Visiting Project Coordinator:** Yuline C. Fitial, Project Coordinator for the Healthy Outcomes for Maternal and Early Childhood (H.O.M.E.) Visiting Program. In 2007 she graduated with a BA in Human Development with a concentration in Adolescence from California State University, East Bay. Immediately following graduation worked as a Jr. Behavioral Therapist in the homes and assisted a Speech & Language Pathologist at an intensive speech and language based program in CA. She relocated to Saipan in 2010 and has served as the H.O.M.E. Visiting Project Coordinator until present. Primary duty is to oversee the entire daily functions and operations of the H.O.M.E. Visiting Program. She also served as a council member for the Interagency Coordinating Council and assisted with the revision of the CNMI Early Learning Guidelines.

**Oral Health Project Coordinator:** Agnes K. Ripple, received her certificate of completion from Loma Linda University in Dental Hygiene in 1981. She worked at the Adventist Dental Clinic for 12.5 years as a Dental Auxiliary/Dental Hygienist. In 2003 she graduated from Northern Marianas College with an AA in Business with emphasis in Accounting. She has been working as a hygienist for Public Health Dental Clinic since 1991 and since 2011 has taken on the additional role of Project Coordinator for the Oral Health Project. Ms. Ripple is one of two certified Chamorro Hygienists living in the CNMI.

**Newborn Screener and Family Support Coordinator:** Shiella Marie Perez graduated with ASN from Northern Marianas College, Saipan MP. She is in charge for providing outpatient hearing rescreening and most importantly provides educational and developmental interventions families with children who have hearing loss. Ms. Perez also continues to coordinate events in collaboration with the Shriner's Children Hospital of Honolulu for Specialty Clinics for CSHCN. She recently received a Certificate of Completion in Basic American Sign Language.

The MCH Bureau is under the Division of Public Health. The Division's strategy is to provide comprehensive and holistic community health services, including medical, dental, mental health, substance abuse counseling, 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.

Furthermore, during orientation all MCHB staff are required to complete the MCH 101 training module in the MCH Navigator. The MCH Program Coordinator is working closely with the CHCC Human Resources and Corporate Quality Office to develop training policies for the Bureau. Throughout employment, cross cutting measures such as presentations by other programs and partners about ongoing goals and objectives (i.e. EHDl attending HOME Visiting meetings) and involvement of staff from other programs in community events take place in order to build MCHB's capacity. Some examples also include the CSHCN Coordinator's participation in the Bleeding Disorder Conference and sending employees to various trainings and conferences geared towards family development and

improvement.

The need to build and improve the workforce for sustainability of the public health programs is imperative to improving delivery of services to the community. The shortage of local manpower impacts health service delivery in that there is a need to recruit manpower from the U.S.. 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 program will work closely with CHCC leadership to develop competent, committed and compassionate MCH professionals.

### **II.F.3. Family Consumer Partnership**

The CNMI MCHB has focused efforts to meet the demands of the transition of our governing entity into a semi-autonomous government agency, setting the structure to merge all programs and services for the MCH population into one Bureau, meeting grant requirements, and maintaining services to our target groups. The establishment of a Life Course Theory has influenced the MCH program to not only focus on the health of our MCH groups, but to consider the social and economic factors affecting them across the life span. The MCH Program not only partners with internal programs such as the HOME Visiting and Newborn Hearing Screening Programs, but involves 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 taking strides to include families at all levels of the CNMI Title V Program, the MCH Advisory Committee has recruited a Filipina and Chamorro mother to serve on the committee to ensure that decisions and goals are culturally and linguistically appropriate. With Filipina and Chamorro women accounting for the majority of women in the CNMI, the MCH Advisory Committee felt certain that their recruitment ensures a voice for nearly all women of childbearing age, mothers, and families in the planning and development of the CNMI MCH Title V Services.

Additionally, strategic and program planning, congruent with the integration of programs and services for the Bureau, involved small-group discussions, individual surveys, partnership meetings, social media, and even a “Breakfast Club” meeting involving key leaders in the CNMI. Focus groups were conducted for both enrolled and no longer enrolled families in the H.O.M.E. Visiting Families, High School students from the CNMI Public School System, CSHCN Families, and female inmates incarcerated at the local Department of Corrections. The focus groups were conducted with the intent to assure that strategic and program planning’s are guided through family/consumer input. Surveys were also conducted throughout the communities. Surveys include Kagman Community Health Center telephone surveys, ECCS Surveys for Early Intervention Services families, H.O.M.E. Visiting Program Family Satisfaction Surveys, CSHCN Needs Assessment Survey. Input and guidance was also sought through the use of social media such as with the MCHB Facebook account which allows families to send inquiries by posting directly on timeline and using the private messaging feature. MCHB Programs are responsible to post every week providing educational messages, soliciting input on MCH services, and promoting other program information (i.e. CDC, Office of Women’s Health). Media advertisement through TV commercials, newspapers, magazines and the radio were also developed.

Furthermore, quality improvement took place through Quarterly and Annual Surveys such as with the Family Satisfaction Surveys conducted by HOME Visiting Project Coordinator to rate the services provided by the Family Advocates (home visitors). Newsletters, brochures, and other outreach materials, informing public about MCH Services were also done to improve program awareness. To address adverse birth outcomes in the CNMI, the MCH

Services has launched the first cohort of Group Prenatal Care in collaboration with the WIC Program, in which eight moms were successfully recruited to participate in this launch.

Along with other members of the CNMI MCH Advisory Committee, the two family representatives participated in the development and review of the State Action Plan and the Executive Summary, as part of the Block Grant Development and Review. Additionally, as part of workforce development, the CSCHCN Coordinator and Early Childhood Comprehensive Services Project Coordinator conducted a survey at the Children's Development and Assistance Center (CDAC) for families referred for early intervention services. The survey was developed by the ECCS Project Coordinator to identify how families were receiving information about EIS.

Moreover, for materials development, program brochures that were developed were presented to families first with draft copies detailing MCHB programs and services.

Lastly, families were recruited to participate as "talents" promoting MCH Title V priorities such as teen pregnancy and child obesity prevention. While the families served as "talents," they more importantly served as family advocates recognizable throughout the community.

#### **II.F.4. Health Reform**

As part of the ACA, expansion funds were allocated to the CNMI Medicaid Office. However in August 2014, the Department of Health and Human Services (HHS) determined that the ACA does not apply to the US territories including the CNMI. Therefore, at this time The CNMI does not know if Medicaid will be able to continue expanding services past 2019 when the first round of ACA funding will expire.

#### **II.F.5. Emerging Issues**

The MCH Program continues to serve mothers, children, adolescents, and children and youth with special health care needs. However, continuous evolving issues, such as unemployment and health insurance coverage, remain to serve as a challenge when both providing for and understanding of the needs of the MCH population.

With the intention of applying the Life Course Theory to underserved groups, the MCH Program started working with incarcerated women to understand the health disparities they experience accessing health care services while imprisoned. Many of these women, prior to incarceration, experienced one or more traumatic life event which compounded with poverty, unemployment and single parenthood placed great demands on them. In assessing their use and understanding of the health care system some unique issues emerged aside from the expected difficulties with affording both transportation and services. Many of the women are single mothers who are the primary carrier of Medicaid coverage for their children. They are fearful and unknowledgeable of whether their children's coverage will continue given their incarceration. Interestingly, when assessing their current health status, all female inmates would repeatedly state "not yet" for a health condition that they currently did not have. This could imply that they have a poor outlook on their personal wellbeing and anticipate developing a health issue in the future. The results of the Priority Needs Survey suggests that female inmates are aware of current health issues and ranked their priorities related to reproductive health. However, they expressed being unaware of the available resources and services to obtaining these health needs.

It is important to understand that the CNMI has some defining characteristics which are essential to comprehending the emerging issues affecting the MCH population. Some of these characteristics demonstrate the uniqueness of the CNMI, as a U.S. Territory, and the program's approach to meeting the needs of families served, and include the

following recent summary of an environment scan conducted by the University of Hawaii:

- CNMI, in November 2011, initiated the establishment of the Commonwealth Healthcare Corporation (CHCC), a public corporation. 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 Kagman Section 330 Community Health Center through a co-applicant agreement; the Rota and Tinian Health Centers; and Public Health function and programs.
- The CHCC, since its inception, has struggled with the transition from a government agency to a public corporation. The financial challenges of both the CNMI and CHCC have been severe, and responding to CMS Conditions of Participation has been the most important priority for the CHCC. As a result, the CHCC has not been able to engage in a healthcare transformation planning process.
- CNMI is 4,000 flight miles from Hawaii, the closest state. Travel costs to and from the CNMI are costly since there is only one U.S. carrier that provides direct flights from CNMI to Guam to Honolulu.
- CNMI has a large percentage of the population that are uninsured. The 2010 Census reports the CNMI uninsured population at 34%, more than double the 15% of uninsured in the United States.
- In the CNMI, the Medicaid population is 32%, double the U.S. Medicaid population of 16%.
- CNMI has four private medical healthcare providers and three private insurers.
- CNMI, as well as other U.S. Territories, are capped by legislation on the percentage of Federal Medical Assistance Program (FMAP) funding for the Medicaid program at 55%. In contrast, some states receive over 80%.

Furthermore, 2014 survey results conducted by the Kagman Community Health Center in Saipan shows:

- Chronic disease has a high prevalence, especially the “metabolic syndrome” including obesity, diabetes, hypertension, and hyperlipidemia.
- Health behaviors tend to be poor, with an unhealthy diet and little exercise
- Recommended screening is very low
- Despite this, respondents rate their own health as very good

Other factors remarkable in CNMI affecting health status are:

#### Women/Maternal Health – Perinatal/Infant Health

- Maternity leave is only ten days
- Early term, non-medically elective deliveries mostly done by a private provider that services the tourist births. The CNMI is accessible to Asian countries via direct flights in under five (5) hours. Because of US Citizenship Laws, babies born on US soil are considered US citizens. Therefore the CNMI receives many foreigners who come here specifically to deliver their child.
- Maternal Morbidity (physical and psychological conditions that result from or are intensified by pregnancy such as diabetes, gestational diabetes, eclampsia, depression, etc.)
- Poor newborn care training for mothers and/or caregivers
- Betelnut chewing among pregnant women
- Second hand smoke exposure/smoking in the home

- High occurrence of obesity or excessive weight gain with pregnancy
- Lack of preconception and/or interconception health care
- High incidence of intimate partner violence as well as this being culturally acceptable
- Limited psychiatric services such as postpartum depression screening
- No Medicaid coverage for basic prenatal genetic testing for congenital irregularities

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#### Child Health – Adolescent Health

- High rate of childhood obesity
- No access to school-based health care
- Poor motor vehicle safety regulations such as no child safety car seat law or regulation
- High occurrence of child abuse and maltreatment
- Betelnut chewing initiation at younger ages
- Incidence in bleeding disorders without constant access to blood and blood products in the CNMI

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#### CSHCN

- Lack of integrated services for CSHCN transitioning from adolescence to adulthood
- Limited capacity to navigate the health care and social service systems

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#### Cross Cutting

- Lack of a designated primary care provider due to the high turnover of medical staff
- High rates of unemployment
- Substance abuse in families, including alcohol, tobacco and drugs
- Limited access to adequate health insurance
- Poor integration of public health and community social services to reduce recidivism rates

The implications derived from these surveys and other measures the program considered indicate that the MCHB will continue to provide a collaborative approach to meet some of the issues that hinder the health progression of the targeted domains.

### **II.F.6. Public Input**

The MCH Program continues to provide an open and collaborative approach with various agencies, families, and other stakeholders to facilitate public input. The public input process involved several efforts including placement of the Executive Summary in the local newspapers, web postings on partner websites (i.e. WIC), outreach through email to specific stakeholders, and participation in advisory committees, workgroups, and partnership meetings.

The recent implementation of the CHCC website also provided an opportunity for the program to share information with stakeholders as well as the community. Focus groups were conducted prior to the development of the application. Focus groups were conducted for both enrolled and no longer enrolled families in the H.O.M.E. Visiting Families, High School students from the CNMI Public School System, CSHCN Families, and female inmates incarcerated at the local Department of Corrections. At each focus group, a note taker was also available to ensure information was noted and considered when developing the application. The MCH Bureau also solicited input through Facebook and Twitter. Comments were encouraged through emails directly to the MCH Program Coordinator, social media platforms, and the main phone line at the Division of Public Health. Comments amounted to over 200 including direct input from the outer islands of Rota and Tinian, social media messages, survey results, and notes from stakeholder meetings and focus groups.

On a larger scale, the MCH Program participated in annual events such as the Marianas March Against Cancer (MMAC), Let's Move Marianas Expo, Week of the Young Child, and the Northern Marianas College's (NMC) Charter Day. 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. Statewide needs were also solicited at these events. The MCH Program hosted the first ever CNMI Women's Health Month in May 2015. At each event, the summary of the application was available for consumers, providers, and other stakeholders to review and provide input.

The successful partnerships with other agencies such as the Public School System (PSS), Division of Youth Services (DYS), Early Intervention Services (EIS), and the Let's Move Marianas Alliance (LMMA) also provided an opportunity to solicit input from other professionals and clients. At the 4th Annual Health Safety Conference sponsored by DYS, the CNMI MCH Data Analyst introduced the concepts of the Life Course Model in MCH practices, specifically the importance of ongoing screening throughout a child's life. The recruitment of MCH Services Coordinator will improve partnership collaboration, service coordination efforts, and improve promotion and public awareness of MCH services.

#### **II.F.7. Technical Assistance**

CNMI will be requesting technical assistance to develop strategies to increase the number of maternal health clients who receive dental care during pregnancy. The technical assistance will be used to address barriers Medicaid-enrolled women face in receiving dental care, such as finding dentists that accept Medicaid, low priority given to dental care, misconceptions about the safety and appropriateness of dental care during pregnancy and sporadic guidance given to pregnant women during prenatal care.

CNMI recognizes the opportunity to build public health capacity for MCH through professional development focused on emerging issues and the changing political landscape, including the paradigm of Medicaid Health Homes in care coordination/case or population management and the effects of those who work in Title V. The CNMI would like to request technical assistance to build capacity of the only college in the CNMI to explore possibilities of offering MCH or public health courses.

CNMI is also requesting technical assistance support to build capacity of data assessment and analysis related to child death review data. Support is needed to continue and expand analysis of the data from the child death review system. The focus would be on developing specific profiles, reports and measures for maternal and child health programs and community-based initiatives. In addition, the CNMI needs technical assistance in managing case files and entering data into the system.

### III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$ 469,747	\$ 305,336	\$ 469,747	\$ 394,747
<b>Unobligated Balance</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>State Funds</b>	\$ 395,500	\$ 395,500	\$ 425,761	\$ 425,761
<b>Local Funds</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>Other Funds</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>Program Funds</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>SubTotal</b>	\$ 865,247	\$ 700,836	\$ 895,508	\$ 820,508
<b>Other Federal Funds</b>	\$ 286,476	\$ 286,476	\$ 292,243	\$ 292,243
<b>Total</b>	\$ 1,151,723	\$ 987,312	\$ 1,187,751	\$ 1,112,751

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$ 435,075	\$ 435,075	\$ 436,490	\$
<b>Unobligated Balance</b>	\$ 0	\$ 0	\$ 0	\$
<b>State Funds</b>	\$ 433,257	\$ 433,257	\$ 433,257	\$
<b>Local Funds</b>	\$ 0	\$ 0	\$ 0	\$
<b>Other Funds</b>	\$ 0	\$ 0	\$ 75,000	\$
<b>Program Funds</b>	\$ 0	\$ 0	\$ 0	\$
<b>SubTotal</b>	\$ 868,332	\$ 868,332	\$ 944,747	\$
<b>Other Federal Funds</b>	\$ 402,834		\$ 298,708	\$
<b>Total</b>	\$ 1,271,166	\$ 868,332	\$ 1,243,455	\$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
<b>Federal Allocation</b>	\$ 456,074	\$
<b>Unobligated Balance</b>	\$ 0	\$
<b>State Funds</b>	\$ 0	\$
<b>Local Funds</b>	\$ 0	\$
<b>Other Funds</b>	\$ 458,156	\$
<b>Program Funds</b>	\$ 0	\$
<b>SubTotal</b>	\$ 914,230	\$
<b>Other Federal Funds</b>	\$ 176,255	\$
<b>Total</b>	\$ 1,090,485	\$

### III.A. Expenditures

For fiscal year 2015, the Maternal and Child Health Program expects to expend the total funds of \$456,074. Infants, Mothers, Pregnant Women was budgeted at \$42,791 which is at 09% of the total federal award. Services for Children and Adolescent health was budgeted at \$143,443 which is at 31% of the total federal award (atleast 30% of the total award to be utilized in compliance with the 30%-30% requirements). Services for Children with Special Health Care Needs was budgeted at \$137,624 which is 30% of the total federal award (atleast 30% of the total award to be utilized in compliance with the 30%-30% requirements). Administrative costs was budgeted at \$41,104 which 10% of the total direct costs of the federal grant awarded. Personnel and fringe costs were expended as proposed on the budget breakdown and most of the MCH staff are ongoing FTEs. A total of \$32,807 was budgeted for Other Costs such as personnel training, fuel, educational and promotional materials, vehicle insurance, advertiements and public education, repairs and maintenance, communication costs, frieght costs, and meeting venue rental. A total of \$18,059 was budgeted for Supplies such as office furnitures and fixtures, office supplies, operational supplies, and medical supplies. A total of \$20,247 was budgeted for Travel expenditures for Division of Public Health, Maternal and Child Health staff, and other community partners to attend conferences, meetings, trainings, and reviews.

### III.B. Budget

Fiscal Year 2016 budget proposal of \$456,074 consist of the following: Infants, Mothers, Pregnant Women was budgeted at \$59,203 which is at 13% of the total federal award. Services for Children and Adolescent health was budgeted at \$149,610 which is at 33% of the total federal award (atleast 30% of the total award to be utilized in compliance with the 30%-30% requirements). Services for Children with Special Health Care Needs was budgeted at \$142,470 which is 31% of the total federal award (atleast 30% of the total award to be utilized in compliance with the 30%-30% requirements). Administrative costs was budgeted at \$41,104 which is 10% of the total direct costs of the federal grant awarded. A total of \$33,687 was budgeted for Other Costs such as personnel training, fuel,

educational and promotional materials, vehicle insurance, advertisements and public education, repairs and maintenance, communication costs, freight costs, and meeting venue rental. A total of \$30,000 was budgeted for Travel expenditures for Division of Public Health staff, Maternal and Child Health staff, and other community partners to attend conferences, meetings, trainings, technical assistance and reviews.

The MCH match is budgeted at \$458,156 is comprised of local fund dollars which will comply with the required FY1989 Maintenance of Effort amount. The Other Federal Funds under the control of the MCH Coordinator responsible for the administration of the Title V program is budgeted for the total amount of \$176,255. The overall MCH budget total is \$1,090,485.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Title V-Medicaid MOU.pdf](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [Organizational Charts.pdf](#)

Supporting Document #02 - [Letters of Support\\_CNMI.pdf](#)

## VI. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: Northern Mariana Islands**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>1. FEDERAL ALLOCATION</b>	\$ 456,074	\$ 435,075
<i>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)</i>		
A. Preventive and Primary Care for Children	\$ 149,610 (32.8%)	\$ 130,696 (30%)
B. Children with Special Health Care Needs	\$ 142,470 (31.2%)	\$ 132,697 (30.5%)
C. Title V Administrative Costs	\$ 41,104 (9%)	\$ 39,552 (9.1%)
<b>2. UNOBLIGATED BALANCE</b>	\$ 0	\$ 0
<i>(Item 18b of SF-424)</i>		
<b>3. STATE MCH FUNDS</b>	\$ 0	\$ 433,257
<i>(Item 18c of SF-424)</i>		
<b>4. LOCAL MCH FUNDS</b>	\$ 0	\$ 0
<i>(Item 18d of SF-424)</i>		
<b>5. OTHER FUNDS</b>	\$ 458,156	\$ 0
<i>(Item 18e of SF-424)</i>		
<b>6. PROGRAM INCOME</b>	\$ 0	\$ 0
<i>(Item 18f of SF-424)</i>		
<b>7. TOTAL STATE MATCH</b>	\$ 458,156	\$ 433,257
<i>(Lines 3 through 6)</i>		
A. Your State's FY 1989 Maintenance of Effort Amount	\$ 395,500	
<b>8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL</b>	\$ 914,230	\$ 868,332
<i>(Same as item 18g of SF-424)</i>		
<b>9. OTHER FEDERAL FUNDS</b>		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
<b>10. OTHER FEDERAL FUNDS</b>	\$ 176,255	
<i>(Subtotal of all funds under item 9)</i>		
<b>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</b>	\$ 1,090,485	\$ 868,332
<i>(Partnership Subtotal + Other Federal MCH Funds Subtotal)</i>		

**FY14 Annual Report Budgeted**

<b>1. FEDERAL ALLOCATION</b>	\$ 435,075
A. Preventive and Primary Care for Children	\$ 130,696
B. Children with Special Health Care Needs	\$ 132,697
C. Title V Administrative Costs	\$ 39,552
<b>2. UNOBLIGATED BALANCE</b>	\$ 0
<b>3. STATE MCH FUNDS</b>	\$ 433,257
<b>4. LOCAL MCH FUNDS</b>	\$ 0
<b>5. OTHER FUNDS</b>	\$ 0
<b>6. PROGRAM INCOME</b>	\$ 0
<b>7. TOTAL STATE MATCH</b>	\$ 433,257

**FY16 Application  
Budgeted**

**9. 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;	\$ 12,255
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	\$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration;	\$ 14,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health;	\$ 20,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	\$ 10,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention;	\$ 10,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning;	\$ 10,000



**Form Notes For Form 2:**

None

**Field Level Notes for Form 2:**

None

**Data Alerts:** None

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Northern Mariana Islands**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>I. TYPES OF INDIVIDUALS SERVED</b>		
<b>IA. Federal MCH Block Grant</b>		
1. Pregnant Women	\$ 29,602	\$ 66,065
2. Infants < 1 year	\$ 29,601	\$ 66,065
3. Children 1-22 years	\$ 149,610	\$ 130,696
4. CSHCN	\$ 142,470	\$ 132,697
5. All Others	\$ 63,687	\$ 37,734
<b>Federal Total of Individuals Served</b>	<b>\$ 414,970</b>	<b>\$ 433,257</b>
<b>IB. Non Federal MCH Block Grant</b>		
1. Pregnant Women	\$ 86,839	\$ 15,164
2. Infants < 1 year	\$ 86,839	\$ 15,164
3. Children 1-22 years	\$ 76,419	\$ 129,977
4. CSHCN	\$ 140,463	\$ 129,977
5. All Others	\$ 67,596	\$ 142,975
<b>Non Federal Total of Individuals Served</b>	<b>\$ 458,156</b>	<b>\$ 433,257</b>
<b>Federal State MCH Block Grant Partnership Total</b>	<b>\$ 873,126</b>	<b>\$ 866,514</b>

**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**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>II. TYPES OF SERVICES</b>		
<b>IIA. Federal MCH Block Grant</b>		
1. Direct Services	\$ 351,283	\$ 395,523
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 59,203	\$ 132,130
B. Preventive and Primary Care Services for Children	\$ 149,610	\$ 130,696
C. Services for CSHCN	\$ 142,470	\$ 132,697
2. Enabling Services	\$ 52,396	\$ 19,776
3. Public Health Services and Systems	\$ 52,395	\$ 19,776
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		\$ 40,000
Physician/Office Services		\$ 200,000
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 85,000
Dental Care (Does Not Include Orthodontic Services)		\$ 20,000
Durable Medical Equipment and Supplies		\$ 30,523
Laboratory Services		\$ 20,000
Direct Services Total		\$ 395,523
<b>Federal Total</b>	<b>\$ 456,074</b>	<b>\$ 435,075</b>

**IIB. Non-Federal MCH Block Grant**

1. Direct Services	\$ 390,560	\$ 290,282
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 173,678	\$ 30,328
B. Preventive and Primary Care Services for Children	\$ 76,419	\$ 129,977
C. Services for CSHCN	\$ 140,463	\$ 129,977
2. Enabling Services	\$ 33,798	\$ 71,488
3. Public Health Services and Systems	\$ 33,798	\$ 71,487
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		\$ 290,282
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 Total		\$ 290,282
<b>Non-Federal Total</b>	<b>\$ 458,156</b>	<b>\$ 433,257</b>

**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** 1,071

**1a. Core RUSP Conditions**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing loss	1,031 (96.3%)	2	1	1 (100.0%)

**1b. Secondary RUSP Conditions**

None

**2. Other Newborn Screening Tests**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	1,031 (96.3%)	2	1	1 (100.0%)

**3. Screening Programs for Older Children & Women**

None

**4. Long-Term Follow-Up**

The MCH and CSHCN Program have both effected an Inter-agency Agreement between the Public School System (PSS) Part C of the IDEA and the Commonwealth Healthcare Corporation to provide services to infants and toddlers birth to three 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. For the children identified as having a disability at birth and have surpassed the age of three, they are then transitioned into the "Early Childhood" program that provides services to children ages three through five. Once the children have transitioned out of the "Early Childhood" stage, they are then transitioned into the Special Education Program under PSS in where they will continue to receive ongoing care coordination.

**Form Notes For Form 4:**

In addition to the long-term follow-up care mentioned below, Shriners provide services to the CSHCN until the age of 21. CSHCN are followed up either 2 x year or once a year. Shriners also recommends that the families continue to follow-up with their primary care providers. Furthermore, for Deaf and Hard of Hearing children, they are being followed up by the Audiologist once every 3 months. She continues doing hearing test and hearing aid modification. Since the Audiologist is under the PSS SPED. She will continually provide services at schools until they graduate from high school.

**Field Level Notes for Form 4:**

None

**Form 5a**  
**Unduplicated Count of Individuals Served under Title V**  
**State: Northern Mariana Islands**

**Reporting Year 2014**

		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	1,068	35.0	0.0	14.0	51.0	0.0
2. Infants < 1 Year of Age	1,068	29.0	0.0	5.0	66.0	0.0
3. Children 1 to 22 Years of Age	16,952	51.0	0.0	7.0	42.0	0.0
4. Children with Special Health Care Needs	302	81.0	0.0	13.0	6.0	0.0
5. Others	100	20.0	20.0	20.0	20.0	20.0
<b>Total</b>	<b>19,490</b>					

**Form Notes For Form 5a:**

None

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Per this measure, Pregnant Women include all mothers who had live births, including those with fetal demise.
2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Infants less than year 1 yrs old per this measure include all live births and fetal deaths.
3.	<b>Field Name:</b>	<b>Children 1 to 22 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Please note that per this measure, the data is reflective of children ages 1 through 22 years who had received services at the Commonwealth Healthcare Corporation in CY 2014, and is not a State reflection.
4.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Please note that for "Others," all data have been accounted for through numbers 1 through 4, and thus number 5, "Others," really is supposed to reflect 0. However, as the system won't accept a "0," we have entered a "20" in columns A through F to equal "100%."

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**  
**State: Northern Mariana Islands**

**Reporting Year 2014**

<b>Types Of Individuals Served</b>	<b>Total Served</b>
1. Pregnant Women	1,068
2. Infants < 1 Year of Age	1,068
3. Children 1 to 22 Years of Age	16,952
4. Children with Special Health Care Needs	302
5. Others	0
<b>Total</b>	<b>19,390</b>

**Form Notes For Form 5b:**

None

**Field Level Notes for Form 5b:**

1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	"Pregnant Women" include all mothers who had live births, including those with fetal demise.
2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	"Infants < 1 Year of Age" include all newborns and fetal demises for CY 2014.
3.	<b>Field Name:</b>	<b>Children 1 to 22 Year of Age</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Please note that per this measure, the data is reflective of children ages 1 through 22 years who had received services at the Commonwealth Healthcare Corporation in CY 2014, and is not a State reflection.

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

**State: Northern Mariana Islands**

**Reporting Year 2014**

**I. Unduplicated Count by Race**

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	1,057	13	1	0	601	412	28	2
Title V Served	1,057	13	1	0	601	412	28	2
Eligible for Title XIX	592	4	1	0	204	365	17	1
2. Total Infants in State	1,057	13	1	0	601	412	28	2
Title V Served	1,057	13	1	0	601	412	28	2
Eligible for Title XIX	592	4	1	0	204	365	17	1

**II. Unduplicated Count by Ethnicity**

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	1,056	1	0	1,057
Title V Served	1,056	1	0	1,057
Eligible for Title XIX	591	1	0	592
2. Total Infants in State	1,056	1	0	1,057
Title V Served	1,056	1	0	1,057
Eligible for Title XIX	591	1	0	592

**Form Notes For Form 6:**

None

**Field Level Notes for Form 6:**

None

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

**State: Northern Mariana Islands**

	Application Year 2016	Reporting Year 2014
<b>A. State MCH Toll-Free Telephone Lines</b>		
1. State MCH Toll-Free "Hotline" Telephone Number	(670) 236-8709 x2025	(670) 236-8709 x2025
2. State MCH Toll-Free "Hotline" Name	MCHB Services Coordinator	MCHB Services Coordinator
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"		200
<b>B. Other Appropriate Methods</b>		
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	chcc.gov.mp/index.php/division-of-public-health/maternal-child-health-mch-program	chcc.gov.mp/index.php/division-of-public-health/maternal-child-health-mch-program
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites	www.facebook.com/MCHB67	www.facebook.com/MCHB67
	0	0
6. Number of Hits to the State Title V Program Social Media Websites		228

**Form Notes For Form 7:**

Please note that the MCHB Services Coordinator receives all incoming calls, telephone and cell phone calls, and inquiries that range from the different types of programs under MCHB and their services, Medicaid application assistance and questions, CHCC payment scale waiver fee, family planning assistance and questions, etc.

**Form 8**  
**State MCH and CSHCN Directors Contact Information**

**State: Northern Mariana Islands**

**Application Year 2016**

**1. Title V Maternal and Child Health (MCH)  
Director**

Name	TaAnn Kabua
Title	MCH Director
Address 1	P.O. Box 500409 CK
Address 2	
City / State / Zip Code	Saipan / MP / 96950
Telephone	(670) 236-8710 x2018
Email	tkabuamch@gmail.com

**2. Title V Children with Special Health Care  
Needs (CSHCN) Director**

Name	Ann Maria Satur
Title	CSHCN Coordinator
Address 1	P.O. Box 500409 CK
Address 2	
City / State / Zip Code	Saipan / MP / 96950
Telephone	(670) 664-4841
Email	amsaturmch@gmail.com

**3. State Family or Youth Leader (Optional)**

Name	Antonio Yarobwemal
Title	MCH Services Coordinator
Address 1	P.O. Box 500409 CK
Address 2	
City / State / Zip Code	Saipan / MP / 96950
Telephone	(670) 236-8709 x2025
Email	tyarobwemalmch@gmail.com

**Form Notes For Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**  
**State: Northern Mariana Islands**

**Application Year 2016**

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Women's/Maternal Health: Improve Women's Health Through Cervical and Breast Cancer and Anemia Screening.	New	
2.	Perinatal/Infant Health: Improve Perinatal/Infant Outcomes Through Early and Adequate Prenatal Care Services and Promoting Breastfeeding and Safe Sleep.	New	
3.	Child Health: Improve Child Health Through Providing Vaccinations and Screening for Developmental Delays.	Continued	
4.	Adolescent Health: Improve Adolescent Health by Promoting Healthy Adolescent Behaviors & Reducing Risk Behavior (i.e. drug & alcohol use, bullying) & poor outcomes (i.e. teen pregnancy, injury, suicide)	Continued	
5.	CSHCN: Provide a Medical Home for Children Identified as CSHCN	New	
6.	Cross-cutting: Improve Insurance Status of Children and Pregnant Mothers.	New	
7.	Cross-cutting: Improve Oral Health of Children & Pregnant Mothers	New	
8.	CSHCN: Improve identification of CSHCN Through Screening for Developmental Delays.	New	

**Form Notes For Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 10a**  
**National Outcome Measures (NOMs)**  
**State: Northern Mariana Islands**

**Form Notes for Form 10a NPMs and NOMs:**

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
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	33.9
<b>Numerator</b>	358
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-1 Notes:**

The percent of women receiving prenatal care in the first trimester continues to be adversely affected by the number of tourist deliveries that occur. These compromise one-third of all deliveries yet because of immigration limits, they are unable to come

prior to the third trimester when they are due to deliver.

**Data Alerts:** None

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

**FAD Not Available for this measure.**

**NOM-2 Notes:**

Per this measure, while data on preventive screenings for women were captured, data specific to maternal morbidity was not.

**Data Alerts:**

1.	Data has not been entered for NOM #2. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.
----	--

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

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	1,057
Data Source	Health and Vital Statistics Office.
Data Source Year	2014

**NOM-3 Notes:**

None

**Data Alerts:**

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

**NOM-4.1 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
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	5.7
<b>Numerator</b>	60
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-4.1 Notes:**

None

**Data Alerts:** None

**NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	NR 	NR 	NR 	NR 
2012	NR 	NR 	NR 	NR 
2011	1.0 % 	0.3 % 	10 	1,032 
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, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	0.5
<b>Numerator</b>	5
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-4.2 Notes:**

None

**Data Alerts:** None

**NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.9 %	1.0 %	47	677
2012	6.0 %	0.8 %	51	847
2011	6.3 %	0.8 %	65	1,032
2010	5.7 % ⚡	1.0 % ⚡	33 ⚡	580 ⚡
2009	8.2 %	0.8 %	91	1,107

**Legends:**  
 🚩 Indicator has a numerator <10 and is not reportable  
 ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	5.2
<b>Numerator</b>	55
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-4.3 Notes:**

None

**Data Alerts:** None

**NOM-5.1 Percent of preterm births (<37 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	7.2
<b>Numerator</b>	76
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office
<b>Data Source Year</b>	2014

**NOM-5.1 Notes:**

None

**Data Alerts:** None

**NOM-5.2 Percent of early preterm births (<34 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.4 % ⚡	0.6 % ⚡	16 ⚡	665 ⚡
2012	1.2 % ⚡	0.4 % ⚡	10 ⚡	813 ⚡
2011	2.1 %	0.5 %	22	1,028
2010	1.9 % ⚡	0.4 % ⚡	19 ⚡	1,023 ⚡
2009	2.1 %	0.4 %	23	1,100

**Legends:**  
 📌 Indicator has a numerator <10 and is not reportable  
 ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	2.0
<b>Numerator</b>	21
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-5.2 Notes:**

None

**Data Alerts:** None

**NOM-5.3 Percent of late preterm births (34-36 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.4 %	1.0 %	49	665
2012	6.4 %	0.9 %	52	813
2011	4.7 %	0.7 %	48	1,028
2010	5.8 %	0.7 %	59	1,023
2009	6.1 %	0.7 %	67	1,100

**Legends:**

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	5.2
<b>Numerator</b>	55
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-5.3 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
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	29.8
<b>Numerator</b>	315
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-6 Notes:**

None

**Data Alerts:** None

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

**FAD Not Available for this measure.**

**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

**Legends:**  
 Indicator has a numerator <10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	14.0
<b>Numerator</b>	15
<b>Denominator</b>	1,072
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**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
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	
	<b>2014</b>
<b>Annual Indicator</b>	7.6
<b>Numerator</b>	8
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**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
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	
	<b>2014</b>
<b>Annual Indicator</b>	3.8
<b>Numerator</b>	4
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**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
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	
	<b>2014</b>
<b>Annual Indicator</b>	3.8
<b>Numerator</b>	4
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-9.3 Notes:**

None

**Data Alerts:** None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator

**Legends:**  
 Indicator has a numerator <10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	189.2
<b>Numerator</b>	2
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-9.4 Notes:**

None

**Data Alerts:** None

**NOM-9.5 Sleep-related 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
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	
	<b>2014</b>
<b>Annual Indicator</b>	0.0
<b>Numerator</b>	0
<b>Denominator</b>	1,057
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-9.5 Notes:**

None

**Data Alerts:**

1.	A value of zero has been entered for the numerator in NOM #9.5. Please review your data to ensure this is correct.
----	--

**NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	1,057
Data Source	CNMI CollN Database.
Data Source Year	2014

**NOM-10 Notes:**

None

**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 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	1,057
Data Source	CNMI ColIN Database.
Data Source Year	2014

**NOM-11 Notes:**

None

**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)**

**FAD Not Available for this measure.**

**NOM-12 Notes:**

None

**Data Alerts:** None

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

**FAD Not Available for this measure.**

**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 12 months**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	3.2
Numerator	458
Denominator	14,469
Data Source	CHCC RPMS.
Data Source Year	2014

**NOM-14 Notes:**

None

**Data Alerts:** None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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	
	<b>2014</b>
<b>Annual Indicator</b>	11.4
<b>Numerator</b>	1
<b>Denominator</b>	8,796
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**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
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	
	<b>2014</b>
<b>Annual Indicator</b>	28.1
<b>Numerator</b>	2
<b>Denominator</b>	7,113
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-16.1 Notes:**

None

**Data Alerts:** None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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	
	<b>2014</b>
<b>Annual Indicator</b>	28.2
<b>Numerator</b>	1
<b>Denominator</b>	3,551
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-16.2 Notes:**

None

**Data Alerts:** None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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	
	<b>2014</b>
<b>Annual Indicator</b>	28.2
<b>Numerator</b>	1
<b>Denominator</b>	3,551
<b>Data Source</b>	Health and Vital Statistics Office.
<b>Data Source Year</b>	2014

**NOM-16.3 Notes:**

The apparent "jump" in suicide deaths is due to moving from zero, associated with previous years, to 1 death in 2014.

**Data Alerts:** None

**NOM-17.1 Percent of children with special health care needs**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	2.0
Numerator	302
Denominator	15,448
Data Source	Data source for the numerator is provided by the Early Intervention Services Program/CSHCN Program. Denominator source is based on the 2014 U.S. Census International Database.
Data Source Year	2014

**NOM-17.1 Notes:**

None

**Data Alerts:** None

**NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	46.8
Numerator	111
Denominator	237
Data Source	2013 CSHCN Survey.
Data Source Year	2013

**NOM-17.2 Notes:**

Please note that the data reflective is based on the CSHCN 2013 Survey. Due to recent changes in SSDI Project Officer and the use of the wrong CSHCN survey, the CNMI was unable to collect 2014 data per this measure.

**Data Alerts:** None

**NOM-17.3 Percent of children diagnosed with an autism spectrum disorder**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	0.9
Numerator	114
Denominator	12,484
Data Source	CNMI Public School System.
Data Source Year	2014

**NOM-17.3 Notes:**

None

**Data Alerts:** None

**NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	0.8
Numerator	97
Denominator	12,484
Data Source	CNMI Public School System.
Data Source Year	2014

**NOM-17.4 Notes:**

None

**Data Alerts:** None

**NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	100.0
Numerator	19
Denominator	19
Data Source	CNMI Public School System.
Data Source Year	2014

**NOM-18 Notes:**

None

**Data Alerts:** None

**NOM-19 Percent of children in excellent or very good health**

**FAD Not Available for this measure.**

**NOM-19 Notes:**

Per this measure, the CNMI currently does not track this data but will be requesting TA on tracking such measure.

**Data Alerts:**

1.	Data has not been entered for NOM #19. This outcome measure is linked to the selected NPM 6,11,13,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.
----	---

**NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)**

**FAD Not Available for this measure.**

State Provided Data	
	<b>2014</b>
<b>Annual Indicator</b>	30.0
<b>Numerator</b>	1,117
<b>Denominator</b>	3,729
<b>Data Source</b>	CNMI WIC Program.
<b>Data Source Year</b>	2014

**NOM-20 Notes:**

Per this measure, data used and submitted is from the the CNMI WIC Program and thus is only reflective of the children enrolled in the Program and not reflective of the children in the CNMI as a whole. Rates of overweight and obesity in children continue to rise with a large increase noted between 2013 and 2014.

**Data Alerts:** None

**NOM-21 Percent of children without health insurance**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	50.9
Numerator	7,862
Denominator	15,448
Data Source	CHCC RPMS.
Data Source Year	2014

**NOM-21 Notes:**

Per this measure, the data collected and submitted is reflective of only those children who have visited the Commonwealth Healthcare Corporation in 2014. However, even with the improvement rates for children since 2010, slightly more than half of the CNMI's children are without health insurance. Almost all these children would qualify for Medicaid but are not enrolled and therefore may not receive the appropriate preventive services.

**Data Alerts:** None

**NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	73.5
Numerator	731
Denominator	995
Data Source	CNMI Immunization Registry, Immunization Program.
Data Source Year	2014

**NOM-22.1 Notes:**

Improvement over 2013 but still well below objective.

**Data Alerts:** None

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

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	43.2
Numerator	11,576
Denominator	26,820
Data Source	CHCC Immunization Program Registry.
Data Source Year	2014

**NOM-22.2 Notes:**

None

**Data Alerts:** None

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

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	31.1
Numerator	1,880
Denominator	6,053
Data Source	CHCC Immunization Program Registry.
Data Source Year	2014

**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**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	56.4
Numerator	4,475
Denominator	7,933
Data Source	CHCC Immunization Program Registry.
Data Source Year	2014

**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**

**FAD Not Available for this measure.**

State Provided Data	
	2014
Annual Indicator	55.0
Numerator	4,365
Denominator	7,933
Data Source	CHCC Immunization Program Registry.
Data Source Year	2014

**NOM-22.5 Notes:**

None

**Data Alerts:** None

Form 10a  
National Performance Measures (NPMs)  
State: Northern Mariana Islands

**NPM-1 Percent of women with a past year preventive medical visit**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	19.0	20.0	21.0	22.0	23.0

**NPM-4 A) Percent of infants who are ever breastfed**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	48.0	51.0	54.0	57.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	43.0	45.0	47.0	50.0

**NPM-5 Percent of infants placed to sleep on their backs**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	50.0	55.0	60.0	65.0

**NPM-6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	60.0	64.0	68.0	72.0	76.0

**NPM-9 Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75.0	70.0	65.0	60.0	55.0

**NPM-11 Percent of children with and without special health care needs having a medical home**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	50.0	55.0	60.0	65.0

**NPM-13 A) Percent of women who had a dental visit during pregnancy**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	5.0	10.0	15.0	20.0	25.0

**NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.0	12.0	14.0	16.0	18.0

**NPM-15 Percent of children ages 0 through 17 who are adequately insured**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	55.0	60.0	65.0	70.0

**Form 10b**  
**State Performance/Outcome Measure Detail Sheet**  
**State: Northern Mariana Islands**

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10c**  
**Evidence-Based or Informed Strategy Measure Detail Sheet**  
**State: Northern Mariana Islands**

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10d**  
**National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**

**State: Northern Mariana Islands**

**Form Notes for Form 10d NPMs and SPMs**

None

**NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.**

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0		0.0	100.0	
Numerator	1		0	3	
Denominator	1		1	3	
Data Source	Metabolic Screening Registry	None	None	Pacific Laboratory.	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Newborn screening has just been reinstated in a limited capacity but given the small number of positives (usually <10) the percent who receive timely follow up should be 100%.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	CNMI Newborn Screening services were suspended due to lack of funding, thus there were no newborn screening conducted in 2013. However, we will resume services as soon as the test kits arrive, as we have reinstated the program.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	CNMI Newborn Screening services suspended due to lack of funding. We are looking at strategies to bring back this service. There were no newborn screening conducted in 2012.
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

Please note that due to lack of budget the lab we were working in suspended the service until payment is received. We are looking at strategies to bring back this service. There were no newborn screening conducted in 2011. The only other private lab does not perform this service.

**Data Alerts:**

1.	A value of zero has been entered for the numerator for year 2013 NPM# 01. Please review your data to ensure this is correct.
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**NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)**

	2011	2012	2013	2014	2015
Annual Objective	59.0	59.0	59.0	60.0	60.0
Annual Indicator	59.0	59.0	78.0	78.0	
Numerator	79	79	181	181	
Denominator	134	134	232	232	
Data Source	CSHCN survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
In general, the CSHCN survey is only done every other year, hence the annual objective will be the same for 2 years in a row. The large increase in 2013 may be due to the increased number of surveys obtained, particularly from Rota and Tinian.
- Field Name:** 2013

**Field Note:**  
CSHCN 2013 Survey.
- Field Name:** 2012

**Field Note:**  
The MCH Program is assisting to inform the MCH target group of the updated and revised Patients Rights and Responsibilities. During the Intro to ASQ:3 and ASQ-SE workshop providers see the tool as one that would improve communication with parents. Language is a challenge as interpretation of health is unique in each of the culture that we work with. Preliminary review of 106 surveys completed thus far shows that 57 respondents are satisfied with services and 34 are very satisfied. We will report the survey next year.
- Field Name:** 2011

**Field Note:**  
In the 2010-2011 Family Survey conducted by the Early Intervention Services Program 92% of participants said they know their rights and 93% said they effectively communicate their children's needs.  
We are in the process of printing the 2012 survey. We will be conducting it from September to December 2012.  
We will report survey results next year.

**Data Alerts:** None

**NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	26.9	26.9	27.0	27.0	27.0
Annual Indicator	26.9	26.9	46.1	46.1	
Numerator	36	36	107	107	
Denominator	134	134	232	232	
Data Source	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	In general, the CSHCN survey is only done every other year, hence the annual objective will be the same for 2 years in a row. The large increase in 2013 may be due to the increased number of surveys obtained, particularly from Rota and Tinian. Also, there is no definition of “medical home” on the surveys so there is uncertainty about whether the respondents truly understand what the question is.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	CSHCN 2013 Survey.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	The lack of specialized care in the CNMI continues to be a challenge for our children with special health care needs population. Our work with the Medical Referral Program has provided the children with needed off-island care. Preliminary review of 106 surveys completed thus far shows that children are not getting ongoing care. We will report survey results next year.
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	We will be conducting the 2012 survey from September to December.

**Data Alerts:** None

**NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	59.0	59.0	59.0	60.0	60.0
Annual Indicator	59.0	59.0	56.5	56.5	
Numerator	79	79	131	131	
Denominator	134	134	232	232	
Data Source	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

- Field Name: 2014**

**Field Note:**  
Please note that the data reflective is based on the CSHCN 2013 Survey. Due to recent changes in SSDI Project Officer and the use of the wrong CSHCN survey, the CNMI was unable to collect 2014 data per this measure. However, data from 2014 is not available but between 2010 and 2013, even with an increased response, almost half of families do not have adequate insurance to cover needed services. Additional information is needed from the private sector.
- Field Name: 2013**

**Field Note:**  
CSHCN 2013 Survey.
- Field Name: 2012**

**Field Note:**  
Last year we worked with the Children’s Clinic and conducted a random survey. Parents of CSHCN were verbally asked if their child have insurance. In a 3 month period 73 of 94 respondents answered their child is enrolled in the Medicaid program; 20 have private health insurance and 1 had no insurance. We worked with the family on eligibility assistance to Medicaid. We will report 2013 survey results next year.
- Field Name: 2011**

**Field Note:**  
We reviewed insurance status of children enrolled in EIS and 89% of all children are Medicaid enrollees. In addition out of 96 records we reviewed for the Shriners Clinic, 73% are Medicaid enrollees. There are no uninsured in EIS and 11 of the 96 records we reviewed for Shriners Clinic are uninsured. We included again the question of “Does your child’s health insurance pay for off-island costs?” on the 2012 CSCHN survey

**Data Alerts:** None

**NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	52.2	52.2	53.0	53.0	55.0
Annual Indicator	52.2	52.2	69.8	69.8	
Numerator	70	70	162	162	
Denominator	134	134	232	232	
Data Source	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

- Field Name: 2014**

**Field Note:**  
Please note that the data reflective is based on the CSHCN 2013 Survey. Due to recent changes in SSDI Project Officer and the use of the wrong CSHCN survey, the CNMI was unable to collect 2014 data per this measure. As of 2013, the majority of CSHCN families feel that community services are organized for ease of use. 2014 data is not available. The SSDI Program and the CSHCN Program will conduct the correct version of the CSHCN Survey during the SY 2015-2016.
- Field Name: 2013**

**Field Note:**  
CSHCN 2013 Survey.
- Field Name: 2012**

**Field Note:**  
A review of community-based services listed thus far from surveys completed include Food Stamp, Medicaid, WIC, SPED, EIS services, DD Council, Childcare program, LIHEAP, Head Start. As has been mentioned services for CSHCN are provided mainly by the CNMI Government.
- Field Name: 2011**

**Field Note:**  
From the EIS Family survey, 74% has written comments regarding their positive experiences with the EIS Program – “The staff are very accommodating to our child’s and family needs. They are patient with our child and has helped him move forward on his language delay”; “They help us understand our child’s medical needs”; and “Some positive experience my family has had with the early intervention service are social emotional need/ ways to meet children’s needs, to feel safe and secure, to feel worthy and loyal, to feel acknowledg

**Data Alerts:** None

**NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.**

	2011	2012	2013	2014	2015
Annual Objective	6.7	6.7	7.0	7.0	8.0
Annual Indicator	6.7	6.7	9.9	9.9	
Numerator	9	9	23	23	
Denominator	134	134	232	232	
Data Source	CSHCN survey	CSHCN survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
Please note that the data reflective is based on the CSHCN 2013 Survey. Due to recent changes in SSDI Project Officer and the use of the wrong CSHCN survey, the CNMI was unable to collect 2014 data per this measure. Although the indicator exceeds the objective, still only 10% of YSHCN receive the needed transition services. MCHB intends to put in more work in this area.
- Field Name:** 2013

**Field Note:**  
CSHCN 2013 Survey.
- Field Name:** 2012

**Field Note:**  
We make sure that in parent advocacy training we discuss the importance of making sure that healthcare is one area they need to include in the transition process. We will report survey result next year.
- Field Name:** 2011

**Field Note:**  
We again include the question "Does your child's health care provider discussed transition from pediatrician to adult provider"? in the 2012 CSHCN survey we will be conducting.

**Data Alerts:** None

**NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.**

	2011	2012	2013	2014	2015
Annual Objective	77.0	88.0	77.0	80.0	82.0
Annual Indicator	87.2	76.6	27.7	73.5	
Numerator	1,306	1,605	560	731	
Denominator	1,498	2,095	2,024	995	
Data Source	Immunization Registry	Immunization Registry	Immunization Program	CNMI Immunization Registry, Immunization Program.	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
Inability to use electronic methods to monitor data resulted in decreased rates in 2013. Implementation of EHR in 2014 improved reliability of data. The EHR will continue to be used for data extraction in the future.
- Field Name:** 2013

**Field Note:**  
After discussion with the Immunization Program, the reflected numerator is accurate. When asked about the decrease in the numerator value, the Program stated it is reflective of the many families who are relocating off-island due to the economic situation, and the option now to go to the private clinics providing the immunizations for a charge of \$10.00 administration fee, for non-insured children. The denominator source is from the 2013 U.S. Census Bureau International Programs - International Data Base.
- Field Name:** 2012

**Field Note:**  
These are infant up to 3 years of age. Please note that in discussions with partners this is the age group in which parents do not bring in their children for their immunization until they are going to attend school. The shortage of physicians, lack of transportation and that Medicaid enrollees cannot access services at the private clinic adds to the decrease in numbers.
- Field Name:** 2011

**Field Note:**  
The Immunization walk-in clinic is open Monday to Friday including lunch hours.

Data Alerts: None

**NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.**

	2011	2012	2013	2014	2015
Annual Objective	29.0	29.0	16.0	16.0	15.5
Annual Indicator	27.1	16.3	27.7	24.1	
Numerator	29	23	26	22	
Denominator	1,069	1,413	939	913	
Data Source	Birth Certificate Database	Birth Certificates	Birth Certificate	Health and Vital Statistics Office,	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
Rates decreasing gradually and renewed access to LARCs, following Project Choice model, should help continue the decline.
- Field Name:** 2013

**Field Note:**  
Our partnership with the Teen Talk Live group has increased our outreach work in the prevention of teen pregnancy.
- Field Name:** 2012

**Field Note:**  
Our partnership with the Teen Talk Live group has increased our outreach work in the prevention of teen pregnancy.
- Field Name:** 2011

**Field Note:**  
Source of denominator data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.

**Data Alerts:** None

**NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.**

	2011	2012	2013	2014	2015
Annual Objective	87.6	90.0	65.0	70.0	75.0
Annual Indicator	90.0	65.0	0.0	15.2	
Numerator	2,114	1,613	0	217	
Denominator	2,349	2,482	859	1,427	
Data Source	Dental Clinci	Dental Clinic	Oral Health Project.	CNMI Public School System and the Oral Health Program.	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Per this measure, the Oral Health Program only provides protective sealants to 2nd and 6th graders within the Public School System (PSS) when it resumed its School Sealant Program in November 2014. The Oral Health Program provided protective sealants to #121 PSS 2nd graders and #96 to PSS 6th graders. The denominator data is reflective of both the 2nd and 6th graders enrolled in PSS SY 2014. Through the closure, the gradual increase in sealants provided for children after the closure of the dental clinic remains to be the overall goal till reaching the CNMI's Annual Objective.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	In September 2012 the CNMI Professional Licensing Regulations amended its policies mandating all dental staff to be under the direct supervision of a licensed CNMI dentist. Thus with no licensed dentist employed at the time, the OHP staffs were restricted from providing any type of dental services, including community outreach and the application of fluoride varnish at the PSS elementary schools. As of November 2013, the OHP has had a licensed dentist on board. The CNMI Licensing Board has also amended its restrictions on preventive services to now have fluoride varnish applications allowed to be under the supervision of the the Hygienist. Data source for the denominator is from the CNMI Public School System.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	These are the number of students that participated in the program. As soon as we recruit a dentist we will work with the schools and increase our numbers. Please note that we also cut back on schools participating for school year 2011-2012 due to no dentist.
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

Please note that these are students enrolled in 1st, 5th, and 6 grades. For school year 2010-2011 only public elementary school students participated in the program. Head Start also participated but is not include in the reporting.

**Data Alerts:**

1.	A value of zero has been entered for the numerator for year 2013 NPM# 09. Please review your data to ensure this is correct.
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**NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.**

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator	0.0	0.0	0.0	0.0	
Numerator	0	0	0	0	
Denominator	13,555	13,378	13,303	13,337	
Data Source	Death certificates	Vital Records	Health and Vital Records Office	Health and Vital Statistics Office,	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	No deaths associated with MVA. Source of numerator data is from the Health & Vital Statistics Office. Denominator source data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	There was no child death caused by motor vehicle crashes in 2013. Denominator source data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	There was no child death caused by motor vehicle crashes in 2012. Denominator source data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	There was no child death caused by motor vehicle crashes in 2011. Denominator source data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.

**Data Alerts:**

1.	A value of zero has been entered for the numerator for year 2013 NPM# 10. Please review your data to ensure this is correct.
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2.

A value of zero has been entered for the numerator for year 2014 NPM# 10. Please review your data to ensure this is correct.

**NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.**

	2011	2012	2013	2014	2015
Annual Objective	25.5	52.0	26.0	30.0	35.0
Annual Indicator	51.6	26.0	30.1	47.2	
Numerator	464	169	155	377	
Denominator	899	649	515	798	
Data Source	WIC Program	WIC Program	WIC Program	WIC Program.	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Per this measure, the data collected for both the numerator and denominator only reflect the infants enrolled in the WIC Program. Data illustrates the increased number of mothers breastfeeding at 6 months.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Two Peer to Peer counselors that were recruited early 2012 quit. The Program have recently recruited two more. In addition the nurses that participated in the IBLC training in 2010 are no longer working for the Corporation. Please note that these numbers reflect babies enrolled in the WIC Program. MCH Program's collaboration with WIC has been assisted to increase breastfeeding counseling and education efforts.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Two Peer to Peer counselors that were recruited early 2012 quit. The Program have recently recruited two more. In addition the nurses that participated in the IBLC training in 2010 are no longer working for the Corporation. Please note that these numbers reflect babies enrolled in the WIC Program. MCH Program's collaboration with WIC has been assisted to increase breastfeeding counseling and education efforts.
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	The data is only WIC participants. There were 899 mothers with 6 month old babies enrolled in WIC in 2011.

**Data Alerts:** None

**NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.**

	2011	2012	2013	2014	2015
Annual Objective	98.0	98.5	98.5	98.5	99.0
Annual Indicator	98.1	97.4	98.0	97.5	
Numerator	1,013	1,106	1,043	1,031	
Denominator	1,033	1,135	1,064	1,057	
Data Source	EHDI Surveillance System	EHDI Surveillance	EHDI Surveillance	EHDI Surveillance.	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Newborn hearing screening continues to be close to 99%.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	The increase in live births can be attributed to the increase in birth tourism. These parents refuse the hearing screening test and thus the decrease in our indicator. 30% of live births were to Chinese mothers in CY 2013.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	The increase in live births can be attributed to the increase in birth tourism. These parents refuse the hearing screening test and thus the decrease in our indicator. 30% of live births were to Chinese mothers in CY 2012.
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	The babies that were not screened had other immediate medical needs, were sent off-island for care, or born to tourist mothers.

**Data Alerts:** None

**NPM 13 - Percent of children without health insurance.**

	2011	2012	2013	2014	2015
Annual Objective	80.0	68.4	60.6	60.0	60.0
Annual Indicator	68.4	60.6	56.9	50.9	
Numerator	10,959	9,987	8,821	7,862	
Denominator	16,024	16,469	15,510	15,448	
Data Source	RPMS	RPMS	RPMS	Commonwealth Healthcare Corporation's RPMS.	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2014

**Field Note:**

Numerator data source is from the Commonwealth Health Care Corporation's RPMS. Source of all denominator data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year. Even with the improvement in insurance rates for children since 2010, slightly more than half of the CNMI's children are without health insurance. Almost all of these children would qualify for Medicaid but are not enrolled and therefore may not receive the appropriate preventive services.

2. **Field Name:** 2013

**Field Note:**

Numerator data source is from the Commonwealth Health Care Corporation's RPMS. Source of all denominator data is from the 2013 US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.

3. **Field Name:** 2012

**Field Note:**

The decrease in numbers of children served at CHCC is a result of the temporary closure of the Children's Clinic due to lack of providers in 2012.

4. **Field Name:** 2011

**Field Note:**

Source of denominator data is from the US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.

**Data Alerts:** None

**NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.**

	2011	2012	2013	2014	2015
Annual Objective	22.0	23.0	29.9	29.0	29.0
Annual Indicator	23.3	29.9	20.8	30.0	
Numerator	1,084	1,458	871	1,117	
Denominator	4,645	4,884	4,185	3,729	
Data Source	WIC Program	WIC Program	WIC Program	WIC Program.	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

- Field Name:** 2014

**Field Note:**  
Rates of overweight and obesity in children continue to rise with a large increase noted between 2013 and 2014. MCHB will work closely with WIC on strategies on decreasing overweight and obesity.
- Field Name:** 2013

**Field Note:**  
The national obesity rates among WIC children has declined in 2013 in comparison to 2012 rates by 9.1%. Reasons for the decline in rates include WIC's ongoing nutrition education messages and the new WIC food package changes from the Interim Food Package Rule, in which the food packages now match the nutrition education messages they have been promoting. Promotional messages include decreasing juice intake, giving out cash value vouchers for fresh fruits and vegetables, offering whole grains such as brown rice and 100% whole wheat bread, increasing our cereal options while making sure that 51% of them are whole grains.

The MCH Program refers to WIC Dietician children and pregnant women that needs nutritional counseling.
- Field Name:** 2012

**Field Note:**  
National obesity rates among WIC children declined between 2003 and 2010 from 15.2% to 14.9%. There were 4,884 children enrolled in the program in 2012. The MCH Program refers to WIC Dietician children and pregnant women that needs nutritional counseling.
- Field Name:** 2011

**Field Note:**  
The WIC Program has been a key partner in our work to decreasing childhood obesity. The increase in WIC participants is attributed to reduction of working hours, unemployment, high cost of utility and fuel, etc.

**Data Alerts:** None

**NPM 15 - Percentage of women who smoke in the last three months of pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	1.0	1.4	0.4	0.4	0.0
Annual Indicator	1.4	0.4	2.5	2.8	
Numerator	14	5	27	30	
Denominator	1,033	1,127	1,075	1,057	
Data Source	Chart Review	Chart Review	Chart Review	Health and Vital Statistics Office,	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2014  

**Field Note:**  
 The apparent increase in the percentage of women who smoke in the last three months of pregnancy may be related to better enumeration of tobacco use in pregnancy. Previous information was obtained from a random chart sample but more recently, information is being provided to the Health and Vital Statistics Office through birth certificate data and should be more accurate. Also, it is not clear if the tobacco question includes use with betelnut which is much higher usage but chewed, not smoked.
2. **Field Name:** 2013  

**Field Note:**  
 Chart reviews were conducted to provide the for the numerator by the staff at the Health and Vital Statistics Office.
3. **Field Name:** 2012  

**Field Note:**  
 Chart reviews were conducted to provide the numerator. Again, we were challenged with the data collection as the staff are all newly recruited for the Health and Vital Statistics Office.
4. **Field Name:** 2011  

**Field Note:**  
 Again, this information is not being completed on the birth certificate forms. We are working with Mgr of Vital Statistics Office and Nursing Director on making sure that this information is completed. We conducted a 106 chart reviews of mothers that gave birth last year and found 14 said yes to tobacco. However, it was not documented whether this was smoking or chewing. Betel nut chewing with tobacco is practice here in the CNMI.

**Data Alerts:** None

**NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.**

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator	0.0	0.0	0.0	28.2	
Numerator	0	0	0	1	
Denominator	4,308	3,973	3,701	3,551	
Data Source	Death Certificates	Vital Records	Health and Vital Records Office	Health and Vital Statistics Office.	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	The apparent “jump” in suicide deaths is due to the moving from zero, associated with previous years, to 1 death in 2014.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	There were no suicide deaths this year among youths aged 15 through 19. Denominator data source is US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year. Again, the partnership with Teen Talk Live group has increased our program's activity in this area.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	There were no suicide deaths this year among youths aged 15 through 19. Denominator data source is US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year. Again, the partnership with Teen Talk Live group has increased our program's activity in this area.
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	There were no suicide deaths this year among youths aged 15 through 19. Denominator data source is US Census Bureau, International Programs, International Data Base. All estimates are based on calendar year.

**Data Alerts:**

1.	A value of zero has been entered for the numerator for year 2013 NPM# 16. Please review your data to ensure this is correct.
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**NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.**

	2011	2012	2013	2014	2015
Annual Objective	1.0	1.0	1.0	1.0	1.0
Annual Indicator			0.0	0.0	
Numerator			0	0	
Denominator			7	5	
Data Source	Exempted from reporting	Exempted from reporting	Exempted from reporting	Exempted from reporting.	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	The CNMI is exempted from reporting on this performance measure as we are not a high-risk facility.
2.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	The CNMI is exempted from reporting on this performance measure as we are not a high-risk facility.
3.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	The CNMI is exempted from reporting on this performance measure as we are not a high-risk facility.

**Data Alerts:**

1.	A value of zero has been entered for the numerator for year 2013 NPM# 17. Please review your data to ensure this is correct.
2.	A value of zero has been entered for the numerator for year 2014 NPM# 17. Please review your data to ensure this is correct.

**NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

	2011	2012	2013	2014	2015
Annual Objective	29.5	25.8	33.0	36.0	40.0
Annual Indicator	25.8	29.5	32.7	33.9	
Numerator	266	335	348	358	
Denominator	1,033	1,135	1,064	1,057	
Data Source	State Vital Records	State Vital Records	Health and Vital Records Office	Health and Vital Statistics Office.	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	The percent of women receiving prenatal care in the first trimester continues to be adversely affected by the number of tourist deliveries that occur. These compromise one-third of all deliveries yet because of immigration limits, they are unable to come prior to the third trimester when they are due to deliver.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Data collected were cross-matched for verification between the data provided by the Health and Vital Records Office and the CHCC's Chief OB/GYN.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	We were challenged in the collection of prenatal data as the staff at the Health and Vital Statistics Office are all newly hired. The SSDI Project Coordinator, OB/GYN, Epidemiologist, and myself will meet to discuss this matter to improve data collection.
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	There are 185 missing records in the birth certificate database. We will be pulling medical records to get data on when they came in for first prenatal visits and insurance status.

**Data Alerts:** None

**Form 10d**  
**State Performance Measures (SPMs) (Reporting Year 2014 & 2015)**  
**State: Northern Mariana Islands**

**SPM 1 - The percent of mothers who breastfeed their infants at hospital discharge.**

	2011	2012	2013	2014	2015
Annual Objective	64.0	65.0	39.3	40.0	42.5
Annual Indicator	39.0	84.7	49.8	87.2	
Numerator	403	459	151	922	
Denominator	1,033	542	303	1,057	
Data Source	Discharge Records	Discharge Records	Discharge Records	Health and Vital Statistics Office.	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Numerator value only serves as an estimate due to discharge records indicating that from January to September of 2013, there was no data being collected by L&D staff on mothers who breastfeed their infants at hospital discharge. Numerator value only reflects data from the months of October to December, in which the specific measure began to be documented in the L&D logbooks/discharge records. However, since the mandate of the Quality Assurance/Performance Improvement initiative by the CEO, in which all units and programs under CHCC must submit a monthly quality assessment and performance indicator report, the L&D logbook/discharge records show data has continuously been collected for such measure since October of 2013. Again, both numerator and denominator values are reflective of data collected from October through December.
2.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	This is an estimate as there were missing information on the discharge records. We will review logbooks and charts and report if there are changes. The work with WIC Program for education, counseling, and referrals have enhanced our activities. 09/04/2013- Data source for this reporting year is L&D logbooks due to incomplete data on breastfeeding information in birth records. Data was collected at L&D only for babies born within the first six months in 2012. Numerator and denominator now reflects data collected from January to June 2012 only.
3.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	This data is from the Labor and Delivery Unit logbooks. We are working with Labor and Delivery, Nursery, and Health and Vital Statistics new Electronic Birth Record systems to collect more accurate data for this state priority.

**Data Alerts:** None

**SPM 2 - Percent of pregnant women enrolled in the Medicaid Program receiving prenatal care beginning in the first trimester.**

	2011	2012	2013	2014	2015
Annual Objective	30.0	30.0	30.0	30.0	30.0
Annual Indicator	20.0	39.6	30.8	31.8	
Numerator	72	90	139	118	
Denominator	360	227	451	371	
Data Source	Chart Review	Chart	Chart Review	Chart Review	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

Although there is an increase in our numbers we still are challenged by Medicaid enrollees not accessing care. The opening of the FQHC and, recently, the Kagman Community Health Center provides another access site for the Medicaid population. Please note that we provide information on what services including screening, lab work, pharmaceuticals, etc. that Medicaid pays for.

The denominator (451) reflects the total number of pregnant women enrolled in the Medicaid Program that receive prenatal care. Of these 139 received prenatal care beginning in the first trimester. Please note there are four other private clinics on-island.

2.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

Although there is an increase in our numbers we still are challenged by Medicaid enrollees not accessing care. The opening of the FQHC provides another access site for the Medicaid population. Please note that we provide information on what services including screening, lab work, pharmaceuticals, etc. that Medicaid pays for.

3.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

According to the logbook from the women's clinic there were 40 women enrolled in Medicaid Program receiving prenatal care beginning in the first trimester at CHCC. Please note that there are 4 other private clinics on Saipan performing prenatal services. Also note that we were not able to get the denominator before the due data from the Medicaid Program, so we will use last year's number. Chart review conducted after data submission.

**Data Alerts:** None

**SPM 3 - Provision of case management of pregnant women identified as "high risk"**

	2011	2012	2013	2014	2015
Annual Objective	1.0	1.0	16.0	16.0	17.0
Annual Indicator					
Numerator	16	15	18	39	
Denominator	21	21	21	21	
Data Source	Women's Clin	Women's Clinic	Women's Clinic	CHCC Women's Clinic	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2013</b>
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**Field Note:**

This performance measure is a scale rating to ensure that case management of high-risk pregnancies continues to be provided by putting systems in place to ensure the service. Currently at the Women's Clinic, there are 5 providers: 2 OB/GYN, 1 Certified Nurse Midwife and 2 Nurse Practitioner. There are 4 full-time nurses stationed at the the Women's Clinic; 2 Registered Nurse and 2 Licensed Practical Nurse.

2.	<b>Field Name:</b>	<b>2012</b>
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**Field Note:**

This performance measure is a scale rating to ensure that case management of high-risk pregnancies continues to be provided by putting systems in place to ensure the service. With the resignation of 2 OB/GYNs last year, there were no training conducted. The health tracker materials were requested to be purchased by the mid-level provider in charge of case management to assist patients track their numbers. There are 7 characteristics to this performance measure to be in place for case management of high risk pregnancies.

3.	<b>Field Name:</b>	<b>2011</b>
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**Field Note:**

There were 49 women that were either diabetics or developed gestational diabetes and 9 women with elevated BP last year. Please note that there is only 1 OB/GYN now at the Women's Clinic. With the departure of Dr. Grant no supplies (strips) were ordered and I met with the nurse to inform her to let me know and MCH will procure the needed supplies.

**Data Alerts:** None

**SPM 8 - The rate of birth (per 1,000) for Chamorro teenagers aged 15 through 18 years.**

	2011	2012	2013	2014	2015
Annual Objective	29.0	29.0	27.0	25.0	25.0
Annual Indicator	27.2	13.4	17.5	14.8	
Numerator	42	18	22	18	
Denominator	1,544	1,345	1,260	1,218	
Data Source	Birth Records	Chart Review	Chart Review	Health and Vital Statistics Office.	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

- Field Name:** 2014

**Field Note:**  
Per this measure, the denominator source is the 2014 Census International Database as we do not have a single aged database that sorts by ethnicity.
- Field Name:** 2013

**Field Note:**  
MCH partnership with Teen Talk Live has strengthened our outreach work in the prevention of teen pregnancies and continues to identify strategies to decrease teen birth rates.

There were 46 teen births aged 15-18 years. Of the 46 pregnancies, 22 were from Chamorro teenagers. Per the 2013 US Census Bureau International Data Base Pop Est, there are 1,260 female teens aged 15-18 years in the CNMI.
- Field Name:** 2012

**Field Note:**  
MCH partnership with Teen Talk Live has strengthened our outreach work in the prevention of teen pregnancies. One future activity is to conduct focus group with Chamorro teens to identify strategies to decrease birth rate.
- Field Name:** 2011

**Field Note:**  
Due to unavailability of 2010 US Census Report denominator data source is 1999 SPC Pop Estimate. Per the 2011 YRBS, Among high school students who had sexual intercourse during the past 3 months, the percentage who used birth control pills to prevent pregnancy before last sexual intercourse remained the same 13.9 in 2009 and 13.9 in 2011. Denominator: Pending release of 2010 Census Data with ethnic breakdown of population.

**Data Alerts:** None

**SPM 9 - Percentage of high school students who ever had a drink of alcohol, other than a few sips**

	2011	2012	2013	2014	2015
Annual Objective	15.0	50.4	50.0	50.0	50.0
Annual Indicator	50.4	50.4	68.6	68.6	
Numerator	2,569	2,569	1,656	1,656	
Denominator	5,093	5,093	2,414	2,414	
Data Source	PSS - YRBS	PSS-YRBS	PSS-YRBS	Public School System-YRBS	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d SPMs:**

- Field Name: 2014**

**Field Note:**  
Per this measure, please note that the data used for reporting year 2014 is reflective of reporting year 2013 as the Public School System (PSS) conducts the YRBS every two years, with the last completed YRBS in 2013. PSS will be compiling results of 2015 YRBS by the end of this year.
- Field Name: 2013**

**Field Note:**  
2013 High School YRBSS Survey was completed and provided by PSS . After talks with the PSS Office if Instructional Services regarding the values for both the numerator and denominator, the denominator is based on the total number of students, from all three participating public high schools, who were allowed to participate in the survey by returning the signed parental consent letter prior to survey taking. The numerator reflects the percentage of these students who ever had a drink of alcohol, other than a few sips.
- Field Name: 2012**

**Field Note:**  
2013 YRBSS Survey completed and will be provided by PSS once results are received. Again, our partnership with Teen Talk Live group has increased our outreach work in the prevention of underage drinking.
- Field Name: 2011**

**Field Note:**  
Per the 2011 YRBS, the Percentage of high school students who had at least one drink of alcohol on one or more of the past 30 days 38.8 in 2009; 41.4 in 2011. The data for this SPM is from YRBS as recommended by partners.

**Data Alerts:** None

**SPM 10 - The percent of of infants with a diagnosis at birth input into the Birth Defects Registry within 6 months and referral to Early Intervention Services Program**

	2011	2012	2013	2014	2015
Annual Objective	3.0	1.2	8.1	2.5	3.0
Annual Indicator	2.5	8.0	1.6	0.8	
Numerator	26	91	17	8	
Denominator	1,033	1,135	1,064	1,060	
Data Source	Birth Defects Database	Birth Defects	EIS Program	Early Intervention Program	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Please note that the only tracking mechanism, per this measure, is through the referrals faxed/sent to the Early Intervention Program from the CHCC NICU ward as the Birth Defects Registry is no longer in use. MCH and the SSDI Program is looking to explore the Electronic Health Records (EHR) system used at CHCC to see if the system can track birth defects. In the meantime, data fields per this measure will be incorporated into the Title V Repository data base.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	EIS Program reported that 17 referred infants born in 2013 were referred to their program for birth defects. The state Health and Vital Statistics Office did not capture anomalies for any of the 2013 births. We are currently working with HSVO to address this concern and have anomalies recorded onto state issued birth certificates. Thus data is provisional. The Annual Performance Objective for this measure is 2.2.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	These babies were all referred to EIS Program. Please note that some of them have already been referred by NICU but only as for example B/G Aldan. Then when we input and get the names we are finding that B/G Aldan is now Marissa Aldan. Again, this has increased our referral rates for infants less than 1 year of age to EIS program.
4.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	The low number is because this information is not being completely filled out in the birth certificate form. MCH is providing staffing support to ensure completion of information. Also, birth certificate forms will be color coded so that individuals responsible to fill out information will know which ones to complete. Numerator updated; data source is Early Intervention Services due to incomplete data in Birth Certificates.

**Data Alerts:** None

**SPM 11 - Percent of children aged 6 months to 5 years that receive fluoride varnish application at the Children's Clinic**

	2011	2012	2013	2014	2015
Annual Objective		15.9	16.0	16.0	17.0
Annual Indicator	15.9		7.3	49.4	
Numerator	739		50	600	
Denominator	4,645		687	1,214	
Data Source	Dental Clinic; WIC Program	Dental Clinic	RPMS	CHCC RPMS.	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Per this measure, both the numerator and denominator data are reflective of children ages 6 months through 5 years old who have received a fluoride varnish application at the Oral Health Program and was seen at the Oral Health Program, respectively, in CY 2014.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Despite the limitations in 2012 set by the CNMI Professional Licensing Regulations, the OHP was eventually able to administer fluoride varnish applications with the Licensing Board amending its restrictions to allow a Hygienist to supervise the applications of fluoride varnish. The provision of fluoride varnish at the Children's Clinic was conducted under the supervision of the Hygienist from January to November 2013. Fluoride varnish applications were also conducted during the summer at the WIC Program, again under the supervision of the Hygienist. As of November 2013, the OHP has had a licensed dentist on board, thus from then on, all dental services resumed at the OHP.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	The provision of fluoride varnish will be enhanced once we recruit a dentist and the Dental Clinic opens. One future activity is the training of non-dental professionals in this area. We also will continue with services at the Children's Clinic and WIC Clinic and expand to child care centers. Unfortunately the Dental Clinic closed down in March 2012 and the service to provide fluoride varnish was suspended. Therefore, there will be no data reported for 2012.
4.	<b>Field Name:</b>	<b>2011</b>

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**Field Note:**

Please note that these were the number of children we saw at the WIC Clinic last summer (2 month period). We will be tracking the numbers with Children's Clinic for reporting next year. The numerator was provided by the Dental Clinic and denominator was provided by WIC Program. These are children we saw age 2 to 5.

**Data Alerts:** None

**Form 11**  
**Other State Data**

**State: Northern Mariana Islands**

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

## State Action Plan Table

### State: Northern Mariana Islands

Please click the link below to download a PDF of the State Action Plan Table.

[State Action Plan Table](#)