



# **HRSA**

Health Resources & Services Administration



Title V MCH Block Grant Program

# **NORTHERN MARIANA ISLANDS**

State Snapshot

FY 2016 Application / FY 2014 Annual Report

April 2016

### Title V Federal-State Partnership – Northern Mariana Islands

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY 2016 Application / FY 2014 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website ( <https://mchb.tvisdata.hrsa.gov> )

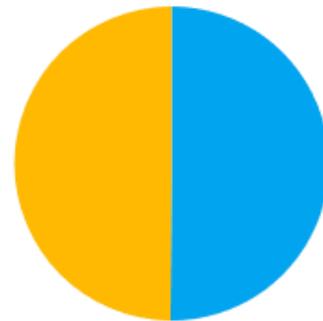
#### State Contacts

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#### Funding by Source

Source	FY 2014 Expenditures
Federal Allocation	\$435,075
State MCH Funds	\$433,257
Local MCH Funds	\$0
Other Funds	\$0
Program Income	\$0

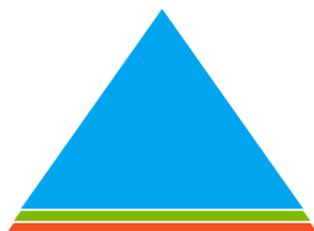
FY 2014 Expenditures



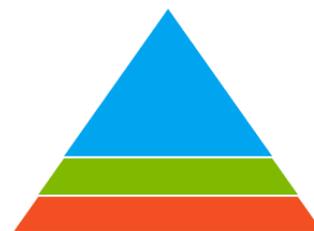
#### Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	\$395,523	\$290,282
Enabling Services	\$19,776	\$71,488
Public Health Services and Systems	\$19,776	\$71,487

FY 2014 Expenditures Federal



FY 2014 Expenditures Non-Federal



### Total Reach of Title V in Serving MCH Populations

Populations Served	Individuals Served	FY 2014 Expenditures	%
 Pregnant Women	1,068	\$81,229	9.4%
 Infants < 1 Year	1,068	\$81,229	9.4%
 Children 1-22 Years	16,952	\$260,673	30.1%
 CSHCN	302	\$262,674	30.3%
 Others *	0	\$180,709	20.9%
Total	19,390	\$866,514	100%

FY 2014 Expenditures



FY 2014 Individuals Served



\*Others– Women of childbearing age, over age 21, and any others defined by the State who are not otherwise included in any of the other listed classes of individuals.

### Selected National Performance Measures

Measure #	Measure Short Name	Population Domain
NPM 1	Well-Woman Visit	Women/Maternal Health
NPM 4	Breastfeeding	Perinatal/Infant Health
NPM 5	Safe Sleep	Perinatal/Infant Health
NPM 6	Developmental Screening	Child Health
NPM 9	Bullying	Adolescent Health
NPM 11	Medical Home	Children with Special Health Care Needs
NPM 13	Preventive Dental Visit	Cross-Cutting/Life Course
NPM 15	Adequate Insurance	Cross-Cutting/Life Course

### Communication Reach

Communication Method	Amount
 State Title V Website Hits:	0
 State Title V Social Media Hits:	228
 State MCH Toll-Free Calls:	200
 Other Toll-Free Calls:	0



## 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

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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 CoIN to Reduce Infant Mortality was implemented. Select members of the CNMI CoIN Team took part in the August 2014 Region IX Pacific Basin Infant Mortality CoIN 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 CoIN 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

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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 CSHCN 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